Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Franetta Sallee

2. Date of Death Month/Day/Year: September 30 1997

3. Time of Death: 9:50am

4a. Facility Name (If not institution, give street and number): Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 058-32-2210

6. Sex: 1☐ M 2☒ F

7. Age (If yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02/07/40

9. Birthplace (State or Foreign Country): NASHVILLE, TN.

Usual Residence of Decedent

10a. State: MD.

10b. County: P.G. Co.

10c. City, Town or Location: ACCOKEEK

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2009 NORTH ALLEVA CT.

10f. Zip Code: 20607

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): SUNNIE BETTS

18. Mother's Name (First, Middle, Maiden Surname): ESSIE SMITH

19a. Informant's Name/Relationship (Type, Print): FRANETTA SALLEE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 79 STEVENS ST. BUFFALO, N.Y. 14215

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FOREST LAWN CEM.

Date: Oct. 6 1997

20c. Location - City or Town, State: BUFFALO, N.Y.

21. Signature of Funeral Service Licensee: ▶ Thomas J. Skarda Jr.

22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST BALTO., MD. 21224

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac arrest

Due to (or as a consequence of): b. Sickle Cell Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Vanessa Allen, M.D.

29c. License number: D44864

29d. Date signed (Month, Day, Year): Oct. 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vanessa Allen, MD. 15901 Indian Head Hwy, Accokeek, Md. 20607

State Registrar

31. Date filed (Month, Day, Year): OCT 15 1997

32. Registrar's Signature: ▶ Judith Davidson-Randall

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31002

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT F. SNYDER

2. Date of Death: Month: October Day: 11 Year: 1997

3. Time of Death: 11:35 AM

4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital 900 Caton Ave

4b. City, Town, or Location of Death: Baltimore MD 21229

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 705-12-0325

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 23, 1905

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 24 NORTH MORLEY STREET

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MACHINIST

16b. Kind of Business/Industry: WESTERN ELECTRIC

17. Father's Name (First, Middle, Last): JOHN SNYDER

18. Mother's Name (First, Middle, Maiden Surname): MARY ELIZABETH DeBOY

19a. Informant's Name/Relationship (Type, Print): JOSEPH L. HEMLER, JR (SON-IN-LAW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 104 BAYVIEW - GRASONVILLE, MD 21638

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

Date: 10/14/97

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Steven L Klug

22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — hours

Due to (or as a consequence of):

b. pneumania — hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

atrial fibrillation

dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeannine Saunders MD

29c. License number: D33061

29d. Date signed (Month, Day, Year): October 11, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeannine Saunders 900 Caton Avenue Baltimore 21229

State Registrar

31. Date filed (Month, Day, Year): OCT 15 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the [illegible] after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

NAME: Robert Snyder

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31003

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mary Angela Suchanek
2. Dete of Deeth: Month October Day 11 Year 1997
3. Time of Death: 7:15 pm
4e. Facility Name (If not institution, give street end number): Franklin Woods Nursing Center
4b. City, Town, or Location of Death: Rossville
4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 705-10-8676
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Feb. 19, 1909
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2110 Tred Avon Road
10f. Zip Code: 21221
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Secretary
18b. Kind of Business/Industry: Federal Government
17. Fether's Neme (First, Middle, Last): Francis Snyder
18. Mother's Neme (First, Middle, Meiden Surneme): Elizabeth Barrett
19e. Informent's Name/Reletionship (Type, Print): Phillip James Suchanek (SON)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 9227 Bowline Rd. Baltimore, Maryland 21236
20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Gardens Of Faith
Dete: 10/15/1997
20c. Locetion - City or Town, Stete: Baltimore, Co. Md.
21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	CONGESTIVE HEART FAILURE	1 MONTH
Due to (or es a consequence of):		
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest b.	CORONARY ARTERY DISEASE	1 YEAR
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE; CANCINOMA BREAST, HISTORY; DEMENTIA

23b. Did tobecco use contribute to the cauee of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Charles F. Roesch, MD

29c. License number: 020390

29d. Dete signed (Month, Dey, Yeer): October 13, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): CHARLES F. NOESCH, MD, 9712 BELAIR RD., BALTO, MD 21236

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 15 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys M. Williams
2. Date of Death: Month 10 Day 11 Year 97
3. Time of Death: 1840
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-14-6511
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 28, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 234 Stonecroft Rd. Apt. E
10f. Zip Code: 21229
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Typist
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Sandy W. Jackson
18. Mother's Name (First, Middle, Maiden Surname): Mary V. Corbin

19a. Informant's Name/Relationship (Type, Print): Larry Williams - Brother-in-law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6909 23rd Ave, Hyattsville, MD. 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland National
Date: October 20, 1997
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Carlton C. Douglass
22. Name and Address of Facility: Douglass Funeral Service 1701 McCulloh Street, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Adult Respiratory Distress Syndrome
Due to (or as a consequence of):
c. Acute Renal Failure
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Matt Mund, MD Resident
29c. License number: PD 9758
29d. Date signed (Month, Day, Year): 10/11/97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Matthew M. Bruckel, MD 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 15 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31005

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARVIN V. WILLIAMS

2. Date of Death — Month: 10 Day: 9 Year: 97

3. Time of Death: 4:45P

4a. Facility Name *(If not institution, giva street and number)*: MANORCARE HEALTH SERVICES RUXTON

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 231-32-5807

6. Sax: 1 ☒ M 2 ☐ F

7. Aga *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: 5/5/1929

9. Birthplaca *(State or Foraign Country)*: VIRGINIA

Usual Rasidance of Decadant

10a. Stata: MD

10b. County: BALTIMORE

10c. City, Town or Location: PARKTON

10d. Insida City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 825 MILLER ROAD

10f. Zip Coda: 21120

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Nevar Married 2 ☒ Marriad 3 ☐ Widowad 4 ☐ Divorcad

12. Was Decedant Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Raca - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*

Elamantary/Secondary (0-12): 6TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: CARETAKER

16b. Kind of Business/Industry: ESTATE

17. Father's Nama *(First, Middle, Last)*: ROY VERSAL WILLIAMS

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: MARGARET CHRISMAN

19a. Informant's Name/Ralationship *(Typa, Print)*: LOIS MILLER (DAUGHTER)

19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 825 MILLER ROAD - PARKTON, MD. 21120

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of cametary, cramatory or othar placa)*: LAKEVIEW MEMORIAL PARK

Data: 10/13/97

20c. Location - City or Town, Stata: SYKESVILLE, MD

21. Signature of Funaral Service Licensee: Susan R Klug

22. Nama and Address of Facility: LOUDON PARKCEMETERY, 4107 WILKENS AVENUE-BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only ona cause on each line.

		Approximata Interval Between Onset and Death
Immedieta Causa (Finel disease or condition rasulting in daath) a.	COPD	10 years
Dua to (or as a consequence of):		
Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or injury that initiated avents rasulting in daath) Last b.		
Dua to (or as a consequence of):		
c.		
Dua to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No

24b. Wara autopsy findings available prior to complation of causa of death? 1 ☐ Yes 2 ☐ No

25. Was casa rafarrad to medical examinar? 1 ☐ Yes 2 ☑ No

26. Placa of Daath *(Check only ona)*

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA

Othar: 4 ☑ Nursing Homa 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Mannar of Death: 1 ☑ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending Investigation 6 ☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 ☑ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and mannar stated.

29b. Signature and titla of cartifier: J. Adams MD

29c. Licansa number: D32783

29d. Data signed *(Month, Day, Year)*: 10/10/97

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): J. Adams MD, 7401 Osler Drive Towson MD 21204

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 15 1997

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31006

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TEURIA ALLEN

2. Date of Death (Month, Day, Year): September 26, 1997

3. Time of Death: 9:40 P.M.

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 455-30-9280

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 6, 1905

9. Birthplace (State or Foreign Country): Nash, Texas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Pepper Mill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 101 Peppermill Drive

10f. Zip Code: 20743

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Wade Canada

18. Mother's Name (First, Middle, Maiden Surname): Mary Wesly

19a. Informant's Name/Relationship (Type, Print): Maurel L. Allen - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6915 Drylog Street, Pepper Mill, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 10/2/97

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — 4 Days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Subendocardial Myocardial Infarction — 3 Days

Due to (or as a consequence of):

c. Conjestive Heart Failure — Few Years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mehru Master - Sonde

29c. License number: D0050514

29d. Date signed (Month, Day, Year): 10/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mehru Master Sonde, MD, 6510 Kenilworth Avenue, Riverdale, MD 20737

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

8

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Julia [illegible]

DHMH 16 Rev 6/95

97-5361-033
CMK
ROBERT L. ANDERSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31007

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decadant's Nama (First, Middla, Last): ROBERT LEE ANDERSON
2. Data of Daath — Month: SEPTEMBER Day: 18, Yaar: 1997
3. Tima of Daath: 2045PM
4a. Facility Nama (If not institution, give straat and number): 4711 HOMER AVENUE APT. A
4b. City, Town, or Location of Death: SUITLAND
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-88-5214
6. Sax: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 33 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): JUNE 18, 1964
9. Birthplaca (State or Foraign Country): WASHINGTON, D.C.

Usual Residance of Dacadant

10a. Stata: MARYLAND
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: SUITLAND
10d. Insida City Limits: 1 [X] Yas 2 [ ] No
10e. Straat and Numbar: 4711 HOMER AVE. APT-A
10f. Zip Coda: 20746
10g. Citizan of What Country?: UNITED STATES

11. Marital Status: 1 [X] Navar Marriad 2 [ ] Marriad 3 [ ] Widowad 4 [ ] Divorcad
12. Was Dacadant Evar in U.S. Armad Forcas? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Spacify:
14. Race - Amarican Indian, Black, White, atc. Spacify: BLACK

15. Decadant's Education (Spacify only highast grada complatad): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): CUSTODIAL ENGINEER
16b. Kind of Businass/Industry: PRIVATE

17. Fathar's Nama (First, Middla, Last): ROBERT LEE ANDERSON, SR.
18. Mothar's Nama (First, Middla, Maidan Surnama): MARY SKERLOCK

19a. Informant's Name/Relationship (Typa, Print): FRIEND MARLENE ANTOINETTE THOMAS/
19b. Mailing Addrass (Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda): 4711 HOMER AVE. APT-A SUITLAND, MARYLAND 20746

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Spacify)
20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): HARMONY MEMORIAL PARK
Date: 10/4/97
20c. Location - City or Town, State: LANDOVER, MD.

21. Signatura of Funaral Sarvica Licansaa: Keith A. Sanye 41085
22. Nama and Addrass of Facility: ALEXANDER S. POPE FUNERAL HOMES, 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. — Approximate Interval Batwaen Onsat and Death

Immadiata Cause (Final disaasa or condition resulting in death): a. Contact Shotgun Wound of Chest
Dua to (or as a consequanca of):
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Diseasa or injury thet initiated avants rasulting in daath) Last:
b. Dua to (or as a consequanca of):
c. Dua to (or as a consequanca of):
d.

Part II. Other significant conditions contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yas 2 [ ] No
24b. Ware autopsy findings available prior to compliation of causa of death? 1 [X] Yas 2 [ ] No

25. Was casa referrad to medical examinar? 1 [X] Yas 2 [ ] No
26. Placa of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Hama 5 [X] Rasidanca 6 [ ] Othar (Specify)
27. Mannar of Daath: 1 [ ] Natural 2 [ ] Accidant 3 [X] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined
28a. Data of Injury (Month, Day Yaar): 9-16-97
28b. Time of Injury: UNK M
28c. Injury at Work? 1 [ ] Yas 2 [X] No
28d. Describe how injury occurred: Subject Shot self
28e. Place of Injury - At hama, farm, streat, factory, office building, atc. (Specify): AT HOME
28f. Location (Street and Numbar or Rural Routa Numbar, City or Town, Stata): 4711 Homer Ave, APT. B 20746

29a. Certifiar (Check only one): 1 [ ] Certifying Phyaician: To tha best of my knowladga, death occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2 [X] Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, death occurrad at the time, data and placa, and dua to the cause(s) and mannar statad.
29b. Signatura and title of certifiar: [signature]
29c. Licansa number: O.C.M.E.
29d. Data signed (Month, Day, Yaar): SEPTEMBER 19, 1997

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): JASON LEE, MD — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Yaar): OCT 02 1997
32. Registrar's Signatura: Julia Henderson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31008

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BETTIE L. ARDIS
2. Date of Death (Month, Day, Year): October 2, 1997
3. Time of Death: 1:45 AM
4a. Facility Name *(If not institution, give street and number)*: Manorcare Health Services
4b. City, Town, or Location of Death: Largo
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-38-3839
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 29, 1931
9. Birthplace *(State or Foreign Country)*: North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7523 Riverdale Road, # 1987
10f. Zip Code: 20784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Green Ollie Stogner
18. Mother's Name *(First, Middle, Maiden Surname)*: Lottie Lee Bowers

19a. Informant's Name/Relationship *(Type, Print)*: Leonard Brooks Ardis-Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7523 Riverdale Road, #1987, New Carrollton, MD 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: October 4, 1997
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Richard Hunt
22. Name and Address of Facility: Rendon/Hale Funeral Home, 9013 Annapolis Road, Lanham, MD 20706

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Terminal Multiple Myeloma — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rakesh Arora, MD
29c. License number: D20108
29d. Date signed *(Month, Day, Year)*: 10/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rakesh Arora, MD, 14300 Gallant Fox Lane, Suite 222, Bowie, MD 20715

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31009

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIVIAN O. ARMSTRONG

2. Date of Death Month / Day / Year: SEPTEMBER 23, 1997

3. Time of Death: 4:00 am

4a. Facility Name *(If not institution, give street and number)*: Fox Chase Rehabilitation Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 576-26-9616

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 21, 1921

9. Birthplace *(State or Foreign Country)*: DC

Usual Residance of Decedent

10a. State: DC

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 601 G Street, S. W. #421

10f. Zip Code: 20024

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Dacedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): ; College (1-4or 5+): 1

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Federal Government

17. Fether's Neme *(First, Middle, Last)*: Charles Howard Ross

18. Mother's Neme *(First, Middle, Maiden Surname)*: Sarah Walker

19a. Informent's Name/Reletionship *(Type, Print)*: Washington Armstrong, Jr. Husband

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 601 G Street, S. W. #421, Wash., DC, 20024

20a. Method of Disposition: 1☒ Burial 2☐ Crametion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or othar place)*: Forest Hills Cemetery

Data: 10/1/97

20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Servise Licensee: R. N. Horton

22. Nama and Addrass of Facility: R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W., DC, 20011

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth)

a. ACUTE MYOCARDIAL INFARCTION ~< 1hr

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in daath) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*:

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*:

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*:

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medicef Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signetura end title of certifier: M. S. Nayar

29c. License number: D-17874

29d. Date signed *(Month, Dey, Yeer)*: 9-24-97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): S. M. NAYAR, M.D. 3717-38th NE COTTAGE CITY, MD 20722

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31010

Physician /Medical Examiner A

1. Decedent's Name *(First, Middle, Last)*: Jennie Sutherland Asbill
2. Date of Death (Month, Day, Year): Sept. 28 1997
3. Time of Death: 10:25 A.M.

4a. Facility Name *(If not institution, give street and number)*: 8100 Connecticut Avenue #325
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-62-2795
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 97 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 30, 1900
9. Birthplace *(State or Foreign Country)*: Jacksonville, FL

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8100 Connecticut Avenue #325
10f. Zip Code: 20815
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4 or 5+): 4+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: P.L. Sutherland
18. Mother's Name *(First, Middle, Maiden Surname)*: Jane Maddox

19a. Informant's Name/Relationship *(Type, Print)*: Jane W. Asbill daughter-in-law
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9717 The Corral Dr., Potomac, MD 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Comfort Crematory
Date: 10/3/97
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. Washington, D.C. 20016

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Heart Failure — Sudden

Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Coronary Artery Disease — years

Due to (or as a consequence of):
c. Arteriolosclerosis — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Decubitus Ulcer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D 31319
29d. Date signed *(Month, Day, Year)*: 9/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Loreto S. Albiol, M. D. 2 Wisconsin Circle, Spence Center Chevy Chase, MD 20815

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 3 0 1997
32. Registrar's Signature: ▶ [signature] Lia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31011

Amend #8, 8/11/97, BMW, Montg.Co, per F.H.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alex Altheim

2. Date of Death (Month, Day, Year): Aug. 7, 1997

3. Time of Death: 11:05am

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 098-24-3414

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~July~~ June 3, 1916

9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6070 California Circle #302

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Administrator

16b. Kind of Business/Industry: New York State Dept. of Labor

17. Father's Name (First, Middle, Last): Osias Altheim

18. Mother's Name (First, Middle, Maiden Surname): Rose Fishman

19a. Informant's Name/Relationship (Type, Print): Dorothy Altheim-Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6070 California Circle #302 Rockville, MD 20852

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): B'Nai IsraelCemetery

Date: 8/8/97

20c. Location - City or Town, State: Oxon Hill, MD

21. Signature of Funeral Service Licensee: -Daniel Simons

22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28e-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute anteroseptal myocardial infarct — 90 minutes

Due to (or as a consequence of):
b. Coronary artery disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes mellitus type II — Years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic lymphocytic leukemia
Pulmonary fibrosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D23958

29d. Date signed (Month, Day, Year): 8/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Burt I. Feldman M.D. 6105 Montrose Rd., Rockville MD 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

20 (20)

State Registrar

31. Date filed (Month, Day, Year): AUG 11 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HUBERT PAUL BAILEY

2. Date of Death Month Day Yaar: SEPT. 28, 1997

3. Time of Death: 3:10 PM.

4a. Facility Name (If not institution, give street and number): WESTMINSTER NURSING HOME

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 219-14-8815

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4/22/1926

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residance of Decadent

10a. Stete: MARYLAND

10b. County: CARROLL

10c. City, Town or Location: WESTMINSTER

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 438 MAPLE AVE.

10f. Zip Code: 21157

10g. Citizen of Whet Country?: USA.

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WW II

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11 / College (1-4or 5+):

16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): MACHINE OPERATOR

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Neme (First, Middle, Lest): MERRITT BAILEY

18. Mother's Neme (First, Middle, Maiden Surneme): FANNIE MAE PETERSON

19a. Informent's Name/Relationship (Type, Print): IRENE S. BAILEY - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 438 MAPLE AVE., WESTMINSTER, MD. 21157

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): EVERGREEN MEM. GARDENS

Dete: 10/1/97

20c. Location - City or Town, Stete: FINKSBURG, MD.

21. Signature of Funeral Service Licensee

22. Name end Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter tha mode of dying, such es cardiec or respiretory errest, shock, or heert feilura. List only one ceusa on aech line.

Approximete Interval Between Onset and Deeth

Immedieta Causa (Finel diseese or condition resulting in deeth)

e. SEPSIS DUE TO GANGRENE — 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. PERIPHERAL VASCULAR DIS. — 5 YEARS

Due to (or es e consequence of):

c. ARTERIOSCLEROTIC CARDIOVASCULAR DIS — 7 YEARS

Due to (or es e consequence of):

d.

Part II. **Other signiflcant conditione** contributing to death but not resulting in the underlying cause given in Part I.: MYELODYSPLASTIC DISORDER

23b. **Did tobacco use contribute to the cauee of death?** 1☑ **Yee** 2☐ No 3☐ **Probably** 4☐ **Unknown**

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evellable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case refarred to medical examinar? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residenca 6☐ Othar (Specify)

27. Mennar of Daeth: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, deta end place, and dua to tha cause(s) end mannar as steted. 2☐ **Medical Examiner:** On the besis of exemination end/or investigetion, in my opinion, deeth occurred et tha tima, date end pleca, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: Daniel I Welliver M D

29c. License number: D11496

29d. Dete signed (Month, Day, Year): SEPT 29 1997

30. Name end address of person who completed causa of deeth (Item 23a) (Type, Print): DANIEL I WELLIVER 912 WASHINGTON ROAD WESTMINSTER MARYLAND 21157

State Registrar

31. Deta filad (Month, Day, Year): OCT 01 1997

32. Registrar's Siggature: Julia Drucker Randall

DHMH 16 Rav 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31013

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: THOMAS P. BARLETT
2. Dete of Deeth Month / Dey / Yeer: October 1, 1997
3. Time of Death: 4:34 pm
4e. Facility Nama *(If not institution, giva street end number)*: DOCTORS HOSPITAL
4b. City, Town, or Location of Death: LANHAM
4c. County of Deelh: PRINCE GEORGES

Funeral Director

5. Social Security Number: 187-42-0788
6. Sex: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: SEPT. 25, 1950
9. Birthplece *(Stete or Foreign Country)*: PA.

Usuel Residence of Decedent

10e. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: GREENBELT
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 56B CRESCENT RD.
10f. Zip Code: 20770
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: SOFTWARE ENGINEER
16b. Kind of Business/Industry: GODDARD SPACE FLIGHT CTR.
17. Fathar's Neme *(First, Middle, Last)*: CHARLES H. BARLETT
18. Mother's Neme *(First, Middle, Meiden Sumame)*: PEARL E. DEIBERT
19e. Informent's Neme/Reletionship *(Type, Print)*: PEARL E. BARLETT/MOTHER
19b. Mailing Address *(Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code)*: 1504 EAST TILGHMAN ST., ALLENTOWN, PA. 18103
20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: CHAMBERS CREMATORY
Dete: 10/2/97
20c. Location - City or Town, Steta: RIVERDALE, MD.
21. Signeture of Funerel Service Licensee: W.W. Chambers M00091
22. Name end Address of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused tha daath. Do not enter the mode of dying, such es cardiec or respiratory arrest, ehock, or heart feilure. List only one ceuse on eech line.

		Approximete Interval Between Onsat and Death
Immediete Ceuse (Finel diseese or condition resulting in death) e.	ACUTE MYOCARDIAL INFARCTION	1 day
Due to (or es e consequence of): b.	VENTRICULAR TACHYARRHYTHMIA	1 day
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest — Due to (or as a consequence of): c.	ANOXIC ENCEPHALOPATHY	1 day
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HODGKIN'S DISEASE; CARCINOMA LUNG

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case refarred to medical exeminar? 1 [ ] Yes 2 [ ] No

26. Plece of Deeth *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [ ] Naturel 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Date of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: V Singh Attnd Phy
29c. License number: D19897
29d. Dete signed *(Month, Dey, Yeer)*: 10297

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): V. SINGH 7209A Hanover Parkway Greenbelt Md 20770

State Registrar

31. Date filed *(Month, Dey, Yeer)*: OCT 03 1997
32. Registrar's Signature: Judith Davidson Barlett

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Thomas Paul Barlett

(8)

97-5666-033
ML

JOHN BOWIE
Items:23a part I,27,28a-f per MEO G-752 10/31/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Sylvester Bowie, Jr.

2. Date of Death (Month, Day, Year): OCTOBER 03 1997

3. Time of Death: 3:45 AM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-56-2402

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-16-42

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decadant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1606 Yuhas Court

10f. Zip Code: 20772

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Butcher

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): John Sylvester Bowie, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Ruth Carol Swann

19a. Informant's Name/Relationship (Type, Print): Barbara Bowie/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1606 Yuhas Court, Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 10/11/97

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: J. B. Jenkins Funeral Home
7474 Landover Road, Lanodver, Maryland 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MULTIPLE INJURIES WITH COMPLICATIONS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 9/22/97

28b. Time of Injury: 8:00 A M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: driver in motor vehicle accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Route 301 and Dyson Rd., P.G. County, Maryland

29a. Certifier (Check only one)

1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. DIXON

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): OCTOBER 04,1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): OCT 08 1997

32. Registrar's Signature: Gabi Madison-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31015

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERTA CORNELIA BIDDLE

2. Date of Death (Month, Day, Year): September 26, 1997

3. Time of Death: 3:45 PM

4e. Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 203-05-5324-

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 12, 1919

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9105 3rd Street

10f. Zip Code: 20706

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Voucher Examiner

16b. Kind of Business/Industry: Internal Revenue Service

17. Fether's Neme (First, Middle, Last): Edward B. Crocker

18. Mother's Neme (First, Middle, Maiden Surname): Ethel G. Miller

19e. Informent's Name/Reletionship (Type, Print): Robert W. Biddle-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9107 3rd Street, Lanham, Maryland 20706

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: October 1, 1997

20c. Location - City or Town, Stete: Brentwood, MD

21. Signature of Funeral Service Licensee: Richard Reed

22. Neme end Address of Fecility: Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in deeth):
e. Anoxic Encephalopathy — Minutes

Due to (or es e consequence of):
b. Atherosclerotic Cardiovascular Disease — years

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or as e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic Obstructive Lung disease

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year): N/A

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, In my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Paul A. DeVore MD

29c. License number: D01852

29d. Date signed (Month, Day, Year): SEPTEMBER 27, 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Paul A. DeVore MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Dete filed (Month, Day, Year): SEP 30 1997

32. Registrer's Signeture: Julia Sheridan Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CR Roberta Cornelia BIDDLE

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31016

Certificate of Death

Reg. No.

Amended #10b per FH G754 12/31/97 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nicholas A. Brown

2. Date of Death Month/Day/Year: September 28 1997

3. Time of Death: 3:30 p.m.

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND SHOCK TRAUMA

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 216-70-9298

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 7, 1957

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residance of Dacedent

10a. State: MARYLAND

10b. County: Howard County ~~CARROLL COUNTY~~

10c. City, Town or Location: MT. AIRY

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 16262 COMPROMISE COURT

10f. Zip Coda: 21771

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowad 4☐ Divorcad

12. Was Decedent Evar in U.S. Armad Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Bleck, Whita, atc. Specify: WHITE

15. Dacadent's Education (Specify only highast grada compltad): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): SELF-EMPLOYED

16b. Kind of Businass/Industry: TOOL SALES

17. Fathar's Nama (First, Middla, Last): GEORGE S. BROWN, SR.

18. Mothar's Nama (First, Middla, Maidan Surname): ETHEL MARTIN

19a. Informant's Name/Ralationship (Type, Print): CHRISTINA A. BROWN, SISTER

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 6006 HOSTA COURT, ELKRIDGE, MARYLAND 21075

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): FORT LINCOLN CEMETERY

Dete: 10/1/97

20c. Location - City or Town, Stata: BRENTWOOD, MARYLAND

21. Signature of Funaral Service Licansaa: Louis L. Hart

22. Nama and Address of Facility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complications that causad tha daath. Do not entar tha moda of dying, such as cardiac or respiratory errast, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Between Onsat and Death

Immediate Causa (Final disasa or condition rasulting in death)

a. Cerebellar Herniation Syndrome

Dua to (or as a consequence of):

CVA

Saquantially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated evants resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Chack only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, death occurred at tha time, data and placa, and due to the causa(s) and mannar statad.

29b. Signatura and titla of certifiar: Jonathan A. Turoff, M.D.

29c. License number: AU417643 T9370

29d. Data signed (Month, Day, Year): September 28, 1997

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print): Jonathan A. Turoff M.D., Dept. of Neurology, 22 South Greene St., Baltimore, MD 21201

State Registrar

31. Data filad (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Theodora Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31017

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM BRYON BRESNAHAN
2. Deta of Death Month / Dey / Yaer: SEPTEMBER 25, 1997
3. Time of Deth: 11:38 AM
4a. Facility Nema *(If not institution, give street end numbar)*: 10111 PHOBBE LANE
4b. City, Town, or Location of Deeth: ADELPHI
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 213-38-1523
6. Sex: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 58 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Dete of Birth *(Month, Dey, Year)*: December 15, 1938
9. Birthplaca *(Stete or Foreign Country)*: Wash., D.C.

To Be Completed by Funeral Director

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Adelphi
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Street end Number: 10111 Phoebe Lane
10f. Zip Code: 20783
10g. Citizan of What Country?: United States

11. Maritai Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yas or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Spacify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: Business Owner
16b. Kind of Business/Industry: Seafood

17. Father's Nama *(First, Middle, Last)*: William A. Bresnahan
18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Springmann

19e. Intorment's Neme/Reletionship *(Type, Print)*: Jane Bresnahan /wife
19b. Melling Address *(Street end Number or Rural Route Number, City or Town, Steta, Zip Code)*: 10111 Phoebe Lane, Adelphi, Maryland 20783

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Nema of cemetery, cremetory or other place)*: Gate of Heaven Cemetery
Dete: 9-29-97
20c. Location - City or Town, Stete: Silver Spring, Md.

21. Signeture of Funeral Service Licensee: Wayne Barker
22. Name end Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Maryland 20904

Physician /Medical Examiner

23e. Pert1. Enter the disaase, or complications thet caused tha deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert teilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es a consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings aveileble prior to completion of causa of deeth? 1 [ ] Yas 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Meiner ot Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time ot Injury
28c. Injury et Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To tha best of *my* knowledge, deeth occurred et the time, deta and place, end dua to tha cause(s) end manner es steted. 2 [X] **Medical Examiner:** On the basis ot examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD DME
29c. License number: D 33954
29d. Data signed *(Month, Day, Year)*: SEPTEMBER 26, 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIE JR MD / 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Dete filed *(Month, Day, Yeer)*: SEP 29 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31018

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert E. Brinkman
2. Date of Death Month Day Year: September 29, 1997
3. Time of Death: 3:56PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 508-14-5807
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): Feb. 3, 1923
9. Birthplace (State or Foreign Country): Nebraska

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Derwood
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 18804 Muncaster Road
10f. Zip Code: 20855
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yas 2☐ No. If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Labor Economist
16b. Kind ot Businass/Industry: Federal Government

17. Father's Name (First, Middle, Last): Fred Earl Brinkman
18. Mother's Neme (First, Middle, Meiden Surname): Violet Abernathy

19a. Intormant's Name/Reietionship (Type, Print): Carolyn J. Brinkman/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 18804 Muncaster Road, Derwood, Maryland 20855

20a. Method ot Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place ot Disposition (Nema of cemetery, cremetory or othar piece): Resthaven Memorial Gardens. Date: Oct. 2, 1997
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Eunaral Servica Licensee: David E. Lesny. M00803
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each lina.

Approximate Interval Between Onset and Death

Immediate Cause (Finei disease or condition resulting in death)
a. Ruptured Aortic Aneurysm — 12 Hours

Due to (or as e consequence ot):
b. Atherosclerotic Vascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequenca ot):
c.

Due to (or as a consequenca ot):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

Hypertension, Diabetes Mellitus, Coronary Atherosclerosis, Prostate Cancer

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece ot Deeth (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner ot Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date ot Injury (Month, Day Year)
28b. Time ot Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece ot Injury - At home, farm, street, tactory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred at the time, dete and piace, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis ot examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Donald R. Lewis MD
29c. License number: D06406
29d. Date signed (Month, Dey, Yeer): SEPTEMBER 30, 1997

30. Name and address ot person who completed cause of death (Item 23e) (Type, Print): DONALD R. LEWIS MD RT108 OLNEY MD 20832

State Registrar

31. Data tiled (Month, Dey, Yeer): OCT 02 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31019

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Olive W. Brome

2. Date of Death Month Day Year: SEPTEMBER 26, 1997

3. Time of Death: 3:00 AM

4a. Facility Name *(If not institution, give street and number)*: 4925 BATTERY LA.

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 517-20-4174

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 30, 1918

9. Birthplace *(State or Foreign Country)*: MONTANA

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: BETHESDA

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4925 BATTERY LA.

10f. Zip Code: 20814

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: EDITORIAL ASSISTANT

16b. Kind of Business/Industry: AMERICAN FISHERIES SOCIETY

17. Father's Name *(First, Middle, Last)*: WILLIAM WHITCOMB

18. Mother's Name *(First, Middle, Maiden Surname)*: ABIGAIL HESS

19a. Informant's Name/Relationship *(Type, Print)*: RALPH W. BROME/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13040 RIDGELY RD., GREENSBORO, MD. 21639

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHAMBERS CREMATORY

Date: 9/27/97

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers M00091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A. SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. LUNG CANCER — 3 1/2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel Rosenblum MD

29c. License number: D04766

29d. Date signed *(Month, Day, Year)*: 9/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL ROSENBLUM 10400 CONNECTICUT AV 606 KENSINGTON, MD 20895

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31020

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Francis Byron

2. Date of Death Month Day Year: September 29 1997

3. Time of Death: 2:35 AM

4a. Facility Name *(If not institution, give street and number)*: Manor Care Nursing Home

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 068-18-2199

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 9 1924

9. Birthplace *(State or Foreign Country)*: Cohoes, N.Y.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9200 Kentsdale Drive

10f. Zip Code: 20854

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Catholic Priest

16b. Kind of Business/Industry: Archdiocese of Wash.

17. Father's Name *(First, Middle, Last)*: William Byron

18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa English

19a. Informant's Name/Relationship *(Type, Print)*: Fr. John J. Enzler /Superior

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9200 Kentsdale Drive Potomac, Maryland 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Gabriels

Date: Oct.2,97

20c. Location - City or Town, State: Potomac, Maryland

21. Signature of Funeral Service Licensee: George C. Wan

22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington,D.C.20007

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Alzheimer's dementia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J Grady

29c. License number: D38781

29d. Date signed *(Month, Day, Year)*: September 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael J. Grady 4910 Massachusetts Ave.,N.W.#312 Washington, D.C. 20016

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31021

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Carolynn Jane Bloch

2. Dete of Deeth — Month: September Dey: 26, Yeer: 1997

3. Time of Death: 11:25 AM

4e. Facility Neme (If not institution, give street end number): Suburban Hospital

4b. City, Town, or Location of Deeth: Bethesda

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 577-72-3399

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): May 2, 1953

9. Birthplace (State or Foreign Country): Washington, DC

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5524 Devon Road

10f. Zip Code: 20814

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Edeution (Specify only highest grede completed): Elementery/Secondery (0-12): 5; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Worker

16b. Kind of Business/Industry: Sheltered Workshop

17. Fether's Neme (First, Middle, Last): Edward J. Bloch

18. Mother's Name (First, Middle, Meiden Surneme): Anne Horvatt

19a. Informent's Neme/Reletionship (Type, Print): Edward J. Bloch/Father

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5524 Devon Road, Bethesda, Maryland 20814

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery

Dete: Sept. 29, 1997

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signeture of Funeral Service Licensee: Ray Faul M00198

22. Neme end Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Bloch, Carolyn J

DS-11

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in deeth)
e. Aspiration pneumonia — 4days

Due to (or es e consequence of):
b. Seizure disorder — 20years

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other signifiicent conditione** contributing to death but not resulting in the underlying ceuse given in Pert I.

tr. Somy 21

Alzheimer's disease

23b. Did tobacco use contributa to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) and menner as steted. 2☐ **Medicel Examiner:** On the besis of exemination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: MD

29c. License number: D33443

29d. Dete signed (Month, Dey, Yeer): September 27, 1997

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Alan R. Pollack, M.D. 809 Viers Mill Rd. Rockville, Md. 20851

State Registrar

31. Dete filed (Month, Dey, Yeer): SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31022

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELBA B. BEALE

2. Data of Death Month: OCT. Day: 2, Yaar: 1997

3. Tima of Death: 8:36 AM

4a. Facility Nama (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-46-9104

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 90 Yrs.

If Under 1 Yeer: Months / Deys

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): JULY 2, 1907

9. Birthplace (State or Foraign Country): UTAH

Usual Residence of Dacedant

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 3707 BETHNAL WAY

10f. Zip Coda: 20906

10g. Citizan of What Country?: U.S.A.

11. Marital Stetus: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American indian, Black, Whita, atc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondary (0-12): Collega (1-4or 5+): 3

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): TEACHER

16b. Kind of Businass/Industry: PUBLIC SCHOOLS

17. Fathar'a Name (First, Middla, Last): UNKNOWN

18. Mothar's Nama (First, Middla, Maidan Sumama): UNKNOWN

19a. Informent'a Name/Ralationship (Type, Print): FREDERIC S. BEALE/HUSBAND

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): SAME AS ITEM #10

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cemetery, cramatory or othar place): CHAMBERS CREMATORY

Date: 10/3/97

20c. Location - City or Town, Stata: RIVERDALE, MD.

21. Signatura of Funeral Service Licensee: W.W. Chambers M00091

22. Nama and Addrasa of Facility: CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart feilura. List only ona causa on aach line.

Approximata Intarval Batween Onset and Death

Immediata Cause (Finai disaase or condition rasulting in daath)

a. Endstage COPD

Dua to (or as a consequance of):

b. Interstitial Fibrosis

Sequentially list conditions, if eny, leading to immadiata causa. Enter Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last

Dua to (or es a consequance of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying cause givan in Part I.

CAD, Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was casa refarred to medical axaminer? 1☐ Yes 2☒ No

26. Placa of Daath (Check only ona) Hospital: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residance 6☐ Othar (Specify)

27. Mennar of Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yaa 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowladge, deeth occurred at tha tima, data and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of examination end/or invastigation, in my opinion, death occurred at tha time, dete and piece, end dua to the cause(s) and mannar stated.

29b. Signatura and title of certifiar

29c. License number: D43202

29d. Dete signed (Month, Day, Year): October 2, 1997

30. Nama and address of person who complated cabsa of death (Item 23a) (Type, Print): C. Ozanne-Blankfard 3305 North Leisure World Blvd Silver Spring maryland 20906

State Registrar

31. Data filad (Month, Day, Year): OCT 03 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31023

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Naomi W. Barry

2. Date of Death (Month, Day, Year): September 24, 1997

3. Time of Death: 6:15 PM

4a. Facility Name (If not Institution, give street and number): Fairland Adventist Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-14-1019

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 103 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20, 1894

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: VA

10b. County: Arlington

10c. City, Town or Location: Arlington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4808 South 23rd Street

10f. Zip Code: 22206

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George W. Warner

18. Mother's Name (First, Middle, Maiden Surname): Annie F. Eyler

19a. Informant's Name/Relationship (Type, Print): Raymond Warner Barry (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2106 Chapman Road Hyattsville, MD 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Weller United Methodist Church Cemetery

Date: 9/29/97

20c. Location - City or Town, State: Thurmont, MD

21. Signature of Funeral Service Licensee: Steven D Strand

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarct — hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Osteoarthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D24997

29d. Date signed (Month, Day, Year): 9/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUIS A. CASAS MD 8317 CHERRY LANE LAUREL MD. 20707

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31024

Item:5 per FH G-753 11/26/97 dh

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Nicholas Bagley

2. Date of Death (Month, Day, Year): September 23,1997

3. Time of Death: 7:00 AM

4a. Facility Name (If not Institution, give street and number): 10000 Brunswick Avenue Apt. 226

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 116-20-3533 ~~116-20-3535~~

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): June 12,1928

9. Birthpiece (Stete or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10000 Brunswick Avenue Apt. 226

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1950 TO 1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Brookwood Nursing Home

17. Father's Name (First, Middle, Last): Floyd Bagley, Sr.

18. Mother's Neme (First, Middle, Maiden Surneme): Florence Horton

19a. Informent's Name/Relationship (Type, Print): Patricia Bagley (Daughter)

19b. Mailing Address (Street end Number or Rural Route Number, CIty or Town, State, Zip Code): 300 Windsor Ridge Court Fredericksburg,Virginia 22405

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Quantico National Cemetery

Date: 9/30/97

20c. Location - City or Town, State: Triangle,Virginia

21. Signature of Funeral Service Licensee: Steven D Grand

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. Congestive Heart Failure

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: VAMC Staff Physician

29c. License number: 0101041579 Virginia

29d. Date signed (Month, Day, Year): September 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lee Ferguson 50 Irving St., NW, Washington, DC 20422

State Registrar

31. Dete filed (Month, Dey, Year): SEP 3 0 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31025

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH F. CANARD
2. Date of Death (Month, Day, Year): SEPTEMBER 30, 1997
3. Time of Death: 6:35 PM
4a. Facility Name (If not institution, give street and number): 5724 39TH AVENUE
4b. City, Town, or Location of Death: HYATTSVILLE
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-30-3176
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/14/13
9. Birthplace (State or Foreign Country): OKLAHOMA

Usual Residance of Decedant

10a. State: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Location: HYATTSVILLE
10d. Inside City Limits: ☒ 1 Yes 2☐ No
10e. Street and Number: 5724 39TH AVENUE
10f. Zip Code: 20781
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Nama (First, Middle, Last): ARTHUR P. FENTON
18. Mother's Name (First, Middle, Meiden Surname): MARIE TRAIL

19a. Informant's Name/Relationship (Type, Print): BETTY KITCHEN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 5310 76TH AVENUE, HYATTSVILLE MARYLAND 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Pleca of Disposition (Name of cametery, cremetory or othar place): FORT LINCOLN CEMETERY
Date: 10-3-97
20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Servica Licensee: ▶ Raisa Dutierrez M00907
22. Nama and Address of Facility: FORT LINCOLN FUNERAL HOME, INC. 3401 BLADENSBURG RD, BRENTWOOD Md 20722

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cardiorespiratory Arrest — 4 min
Due to (or es e consequence of):
b. Advanced Dementia — 6 months

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco uae contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not ba determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) end manner steted.

29b. Signeture and title of certifier: ▶ Phillip W. Poth, MD
29c. License number: D22309
29d. Data signed (Month, Day, Year): October 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Phillip W. Poth, M.D. Suite 32, 831 University Blvd. East, Silver Spring, Md. 20903

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997
32. Registrar's Signeture: ▶ Julia Atwell-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 20b. Per F.H. P.G.C. 10-1-97 cr

Certificate of Death

Reg. No. 97 31026

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Last): Florence E. Cobb

2. Dete of Death — Month: Sept. Dey: 27, Yeer: 1997

3. Time of Death: 5:30 A.M.

4a. Facility Nama (If not institution, giva street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-28-3571

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/1/12

9. Birthplace (State or Foraign Country): Virginia

Usual Residanca of Decedant

10a. Stata: D.C.

10b. County: N/A

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 635 Edgewood St.,N.E. # 411

10f. Zip Coda: 20017

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Wes Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No. If Yes, Giva Yaer or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elamentery/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired): Domestic

16b. Kind of Busmass/Industry: Private Industry

17. Fathar's Nama (First, Middle, Last): John Summers

18. Mothar's Nama (First, Middle, Meiden Surnema): Useal Grigg

19a. Informent's Name/Ralationship (Type, Print): Kendrick A. Summers/Nephew

19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code): 4312 74th Ave.,Hyattsville,Md. 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Piece of Disposition (Nema of cematary, cramatory or othar piece): ~~Ft.~~ Harmony Mem. Pk. Data: 10/3/97

20c. Location - City or Town, State: Landover,Md.

21. Signeture of Funaral Service Licensee: Larry W. Pratt

22. Name end Address of Facility: H.S.Washington & Sons,Inc. 4925 Burroughs Ave.,N.E.

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications thet causad tha death. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onset and Death

Immediata Cause (Finel disaasa or condition rasulting in death)

a. Septicemia

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Diseasa or injury thet initiated avents rasulting in daath) Last

b. Aspirative Pneumonia

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as e consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Cerebrovascular Accident

Paralysis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Chack only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Othar (Specify)

27. Mennar of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of injury - At homa, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, deta end placa, and dua to tha cause(s) and mannar as statad. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigetion, in my opinion, deeth occurred at tha tima, deta end piece, and dua to tha cause(s) and mennar stated.

29b. Signatura and title of cartifier

29c. Licanse number: D14156

29d. Data signed (Month, Day, Year): 9-27-97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Ciro A. Montanez,M.D. 1300 Mercantile Lane,Landover,Md. 20785

State Registrar

31. Data filad (Month, Day, Year): OCT 01 1997

32. Registrar's Signatura: John Chandler Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31027

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kathleen Retta Catlett
2. Date of Death Month Day Year: September 15, 1997
3. Time of Death: 8:10 pm
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-28-9146
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1924
9. Birthplace *(State or Foreign Country)*: Washington, DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4302 Jefferson Street
10f. Zip Code: 20781
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Associate
16b. Kind of Business/Industry: Retail Sales

17. Father's Name *(First, Middle, Last)*: Roland Whaling
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret (Unavailable)

19a. Informant's Name/Relationship *(Type, Print)*: Douglas Dudrow - Councilman
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4202 Kennedy Street, Hyattsville, Maryland 20781

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: George Washington Cemetery — Date: 09/29/97
20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: W.B. Gasch
22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 2 YEARS

Due to (or as a consequence of):
b. ATHEROMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CELLULITIS OF LEGS
HYPOVOLEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D.J. Hand MD
29c. License number: D04899
29d. Data signed *(Month, Day, Year)*: 9/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DENNIS J. HAND MD 4203 QUEENSBURY Rd. HYATTSVILLE MD 20781

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: Julie Dunbar Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31028

Bertha Elizabeth COGGON

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bertha Elizabeth Coggon
2. Date of Death Month Day Year: September 26, 1997
3. Time of Death: 11:45 PM
4a. Facility Name *(If not institution, give street and number)*: Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-26-1550
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 19, 1908
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6409 63rd Place
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cashier
16b. Kind of Business/Industry: General Services Administration

17. Father's Name *(First, Middle, Last)*: William Edward Hadden
18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Sprague

19a. Informant's Name/Relationship *(Type, Print)*: Sandra Meyer - Granddaughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6409 63rd Place, Riverdale, Maryland 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: 10/01/97
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Francis Gasch's Sons Funeral HOme, P.A. 4739 Baltimore Avenue, Hyattsville, MD. 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the *mode* of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASYSTOLE	15 min.
Due to (or as a consequence of): b.	Congestive Cardiac Failure	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last — Due to (or as a consequence of): c.	Myocardial ischemia	yrs.
Due to (or as a consequence of): d.	Atherosclerotic Cardiovascular Disease	yrs.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Insulin Dependent Diabetes Mellitus; Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D22549
29d. Date signed *(Month, Day, Year)*: SEPTEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): G.M. DIN, M.D. 6510 Kenilworth Ave., Riverdale M.D. 20737

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(10)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31029

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD CALIGIURI
2. Date of Death Month / Day / Year: September 26, 1997
3. Time of Death: 4:35AM
4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 116-09-7208
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 19, 1918
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Brookeville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 18712 Considine Drive
10f. Zip Code: 20833
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): +4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Civil Engineer
16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Anthony Caligiuri
18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa Maresca

19a. Informant's Name/Relationship *(Type, Print)*: Mary Caroline Caligiuri/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18712 Considine Drive, Brookeville, MD 20833

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cem.
Date: 9/29/97
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Keri S. Holland
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Acute Myocardial Infarction	1 hour
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robert L Gold MD
29c. License number: 29300
29d. Date signed *(Month, Day, Year)*: September 26, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert L. Gold 15225 Shady Grove Road Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997
32. Registrar's Signature: Jika Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31030

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN A. CANNON

2. Date of Death (Month, Day, Year): Sept. 25 1997

3. Time of Death: 7:57AM

4a. Facility Name *(If not institution, give street and number)*: 143 Old Wharf Road

4b. City, Town, or Location of Death: Ocean City

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 212-20-1382

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 25, 1927

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 143 Old Wharf Road

10f. Zip Code: 21842

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Employee Benefits Manager

16b. Kind of Business/Industry: Newspaper

17. Father's Name *(First, Middle, Last)*: Arthur Cannon

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Flaherty

19a. Informant's Name/Relationship *(Type, Print)*: Marilyn Cannon (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 143 Old Wharf Rd., Ocean City, Maryland 21842

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven

Date: 9-29-97

20c. Location - City or Town, State: Silver Spring, Md.

21. Signature of Funeral Service Licensee: Maurice Richard

22. Name and Address of Facility: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W.,SILVER SPRING,MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-i show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

BMW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 6 months

Due to (or as a consequence of):

b. Contributing Disease — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Toulmat

29c. License number: D47676

29d. Date signed *(Month, Day, Year)*: 9/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN TOULMAT 9733 Healthway Dr. Berlin, MD 21811

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31031

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph P. Carbone

2. Date of Death Month / Day / Year: October 1 1997

3. Time of Death: 12:15 AM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 346-10-6295

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sep. 9, 1902

9. Birthplace *(State or Foreign Country)*: Illinois

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 13023 Morningside Lane

10f. Zip Code: 20904

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Rabies Inspector

16b. Kind of Business/Industry: County Government

17. Father's Name *(First, Middle, Last)*: Joseph Carbone

18. Mother's Name *(First, Middle, Maiden Surname)*: Rosina Carbone

19a. Informant's Name/Relationship *(Type, Print)*: Donald J. Carbone / Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13023 Morningside Lane, Silver Spring, Maryland20904

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: St. Joseph Cemetery — Date: 10/4/97

20c. Location - City or Town, State: River Grove, Illinois

21. Signature of Funeral Service Licensee: Thomas Guyon

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure

Due to (or es e consequence of):
b. Chronic Lung Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Chronic Renal Disease

Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Robert Kramer MD

29c. License number: D0597

29d. Date signed *(Month, Day, Year)*: 10/1/97

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print): Robert Kramer, M.D. 10313 Georgia Avenue, #209, Silver Spring, Maryland 20902

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31032

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BEENA E. CHACKO
2. Data of Death Month: SEPT Day: 24 Year: 1997
3. Time of Death: 1855
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 212-15-5977
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 35 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): June 30, 1962
9. Birthplace (State or Foreign Country): India

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1640 Windingbrook Way
10f. Zip Code: 21244
10g. Citizen of What Country?: India

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: Indian

15. Dacedent's Education (Specify only highest grade completed): Elamentary/Secondery (0-12): 12; College (1-4or 5+): +5
16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired): Monitor Technician
16b. Kind of Business/Industry: Medical

17. Father's Name (First, Middle, Last): V. V. Varghese
18. Mother's Nama (First, Middle, Meidan Sumema): Marykutty Varghese

19a. Informent's Name/Relationship (Type, Print): Varghese Chacko / Husband
19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code): 1640 Windingbrook Way, Baltimore, Maryland 21244

20a. Method of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Placa of Disposition (Name of cematary, crematory or other placa): Gate of Heaven Cemetery
Date: 9/27/97
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Nama and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

BAW

Physician /Medical Examiner

23a. Part1. Entar the disease or complicetions that caused the death. Do not enter the moda of dying, such es cardiac or respiretory arrast, ahock, or haart failure. List only ona causa on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Finel disease or condition resulting in death)
e. RESPIRATORY FAILURE — DAYS

Due to (or as a consequence of):
b. METASTATIC BREAST CANCER — ~2 YEARS

Sequantially list conditions, if eny, laeding to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last

Due to (or as e consequence of):
c.

Dua to (or es a consequance of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the causa of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☑ No

26. Placa of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Tima of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office buiiding, atc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowladge, death occurred et the time, date end piace, end due to the causa(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, death occurred at tha tima, data and piace, and due to the cauae(s) and manner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D 42892
29d. Date signed (Month, Dey, Year): SEPT 24 1997

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): FRANCIS CHUDIAN MD 10724 LITTLE PATUXENT PKWY SUITE 200 COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

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State of Maryland / Department of Health and Mental Hygiene 97 31033

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Eugene Chapman
2. Date of Death Month: Sept Day: 25 Year: 1997
3. Time of Death: 4:20pm
4a. Facility Name (If not institution, give street and number): 12414 DALEWOOD DR.
4b. City, Town, or Location of Death: WHEATON
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 344-24-3016
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB.14,1926
9. Birthplace (State or Foreign Country): ILL.

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: WHEATON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12414 DALEWOOD DR.
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1948-1969
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RET.- 1st/SGT.
16b. Kind of Business/Industry: U.S. ARMY

17. Father's Name (First, Middle, Last): JOSEPH H. CHAPMAN
18. Mother's Name (First, Middle, Maiden Surname): SARAH HUTCHCRAFT

19a. Informant's Name/Relationship (Type, Print): MARIANNE L. CHAPMAN/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKLAWN MEMORIAL PARK
Date: 9/29/97
20c. Location - City or Town, State: ROCKVILLE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers M00091
22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A. SILVER SPRING, MD. 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gun Shot of chest.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): Sept 25 97
28b. Time of Injury: 4:20 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Gun shot of chest
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 12414 Dalewood Dr Wheaton md

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: 20854c
29d. Data signed (Month, Day, Year): Sept 25 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Tauber 8218 Wisconsin ave Bethesda md

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

14 + 1

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Felte Cliggett

2. Date of Death (Month, Day, Year): Sept. 23, 1997

3. Time of Death: 3:00 AM

4e. Facility Name (If not institution, give street and number): 1718 Priscilla Drive

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 162-10-2540

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 5, 1907

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1718 Priscilla Drive

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Associate

16b. Kind of Business/Industry: Jewelry

17. Father's Name (First, Middle, Last): Walter Felte

18. Mother's Name (First, Middle, Maiden Surname): Mary Strugalla

19a. Informant's Name/Reletionship (Type, Print): Patricia C. Vacca / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1730 Priscilla Drive, Silver Spring, Maryland 20904

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Gate of Heaven Cemetery

Date: 9/26/97

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Denise L. Holland

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Buried

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer involving brain — 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph M. Haggerty MD

29c. License number: D 32407

29d. Date signed (Month, Day, Year): SEPTEMBER 25, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph M. Haggerty, M.D. 10605 Concord St., #300, Kensington, Maryland 20895

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: Sylvia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

97-5580-031
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31035

MARK W.CRITZER Items:23part I,27 per MEO G-752 10/20/97

Certificate of Death

RC Reg. No.

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): Mark William Critzer
2. Data of Death (Month, Day, Year): SEPTEMBER 29 1997
3. Tima of Death: 6:01 PM
4a. Facility Nema (If not institution, giva street and number): OLD RIVER ROAD
4b. City, Town, or Location of Death: SENECA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Sacurity Numbar: 212-80-6669
6. Sax: 1 [X] M 2 [ ] F
7. Aga (In yrs. last birthday): 37 Yrs.
If Undar 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): March 23, 1960
9. Birthplaca (Stete or Foreign Country): Maryland

Usual Residanca of Dacadant

10a. Stata: Maryland
10b. County: Montgomery
10c. City, Town or Location: Germantown
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Numbar: 19904 Sweet Gum Circle, #14
10f. Zip Coda: 20874
10g. Citizan of What Country?: United States

11. Marital Status: 1 [X] Navar Marriad 2 [ ] Marriad 3 [ ] Widowad 4 [ ] Divorced
12. Was Dacadant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [XX] No If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: white

15. Decadent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: None

17. Fathar's Nama (First, Middle, Last): William D. Critzer
18. Mothar's Nama (First, Middle, Meiden Surneme): Christine Dwyer

19a. Informant's Name/Ralationship (Type, Print): Tess Critzer sister
19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 39-40 Greenpoint Ave., #3F, Sunnyside, NY 11104

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Crematory
Data: 10-1-97
20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signatura of Funaral Sarvica Licansaa: ▶ Ellen H Rapp
22. Nama and Addrass of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on eech lina. (Approximate Intarval Batween Onsat and Death)

Immediate Cause (Final disaasa or condition rasulting in daath): e. PROBABLE SEPSIS
Due to (or as a consequence of):
Sequantially list conditions, if any, leading to immediate cause. Enter Undarlying Causa (Disaasa or injury that initiatad avents rasulting in death) Last:
b. DECUBITUS ULCERS
Due to (or as a consequanca of):
c.
Due to (or as a consequanca of):
d.

Part II. Othar signifIcant conditions contributing to daath but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Ware autopsy findings available prior to completion of causa of death? 1 [X] Yes 2 [ ] No

25. Was case referrad to medical examinar? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [ ] Residanca 6 [X] Othar (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)
28b. Tima of Injury: M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Data of Injury (Month, Dey Year)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] Certifying Phyeician: To tha best of my knowledga, daath occurrad at the tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [X] Medical Examiner: On tha basis of examinetion end/or invastigation, in my opinion, daath occurrad at tha tima, data and place, and dua to the ceuse(s) and mannar statad.
29b. Signatura and title of certifier: ▶ J. Aron Locke MD
29c. Licansa number: O.C.M.E.
29d. Data signed (Month, Day, Year): SEPTEMBER 30, 1997
30. Neme and address of person who completed cause of daath (Item 23a) (Type, Print): J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997
32. Registrar's Signature: ▶ Gitta Davidson-Randall

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MINNIE LOUISE DELAHA DAIL
2. Date of Death (Month, Day, Year): October 3 1997
3. Time of Death: 5:45 am
4a. Facility Name (If not institution, give street and number): Mallard Bay Nursing Center
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 215-20-1597
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 10 1906
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 312 Crusader Road
10f. Zip Code: 21613
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): retail clerk
16b. Kind of Business/Industry: department store

17. Father's Name (First, Middle, Last): Daniel D. Delaha
18. Mother's Name (First, Middle, Meiden Surneme): Laura Hurst

19a. Informent's Name/Relationship (Type, Print): Mrs. Marian Pearson-daughter
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6023 East Grand, Dallas, TX 75223

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Green Lawn Cemetery
Dete: 10-6-1997
20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth R Thomas Jr.
22. Name and Address of Facility: Thomas Funeral Home PA 700 Locust St. Cambridge, MD 21613

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line.

		Approximete Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	cardiopulmonary arrest	hrs.
Due to (or as e consequenca of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last b.	CHF	years
Due to (or as a consequence of):		
c.	A-fib	years
Due to (or as a consequenca of):		
d.	HTN	years

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- IDDM.
- CVA.
- Hip fracture

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and menner as steted. 2☐ Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ahmed Mowaz
29c. License number: D0050981
29d. Dete signed (Month, Day, Yeer): 10/6/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Ahmed Mowaz 105 Aurora street cambridge MD 21613.

State Registrar

31. Date filed (Month, Day, Yeer): OCT 6 1997
32. Registrar's Signature: Julia Dawson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 10g.Per F.H. P.G.C. 10-10-97 cr — *Certificate of Death* — Reg. No. 97 31037

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARK D'AGUIAR

2. Data of Death Month Day Yaar: SEPTEMBER 27,1997

3. Tima of Death: 00:03

4e. Facility Nama *(If not institution, giva street and number)*: THE JOHNS HOPKINS HOSPTIAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Numbar: 079-66-1962

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 31 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: DEC. 7, 1965

9. Birthplace *(Stata or Foreign Country)*: GUYANA

Usual Rasidanca of Dacadant

10a. Stata: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: UPPER MARLBORO

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 8517 RHEIMS CT.

10f. Zip Coda: 20772

10g. Citizan of What Country? ~~GUYANESE~~ USA

11. Maritel Stetus: 1 [ ] Never Marriad 2 [X] Marriad 3 [ ] Widowad 4 [ ] Divorcad

12. Was Dacedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 1 [ ] Yas 2 [ ] No *Specify:*

14. Race - Amaricen Indien, Black, White, atc. *Specify:* BLACK

15. Decedant's Education *(Specify only highest grada complatad)*: Elamantary/Secondary (0-12): 12 — Collaga (1-4or 5+): 3

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: SYSTEMS ANALYST

16b. Kind of Businass/Industry: FEDERAL GOVERNMENT

17. Father's Nama *(First, Middla, Last)*: SYLVAN D'AGUAIR

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: EILEEN WILLIAMS

19a. Informant's Name/Ralationship *(Type, Print)*: APRIL D'AGUIAR/WIFE

19b. Mailing Address *(Straat and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 8517 RHEIMS CT. UPPER MARLBORO, MARYLAND 20772

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Ramoval from State 4 [ ] Donetion 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar place)*: RESURRECTION CEMTERY

Data: 10/3/97

20c. Location - City or Town, Stata: CLINTON, MD.

21. Signatura of Funaral Sarvice Licansee: Keith G. Savage 11085

22. Nama and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747

Physician /Medical Examiner

23a. Part1. Entar the disasa, or complications thet causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Finat disaasa or condition rasulting in daath)

a. SEPSIS — one month

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury thet initiated avants rasulting in daath) Last

b. IMMUNUSUPPRESSION FROM LIVER TRANSPLANT — one month

Dua to (or as a consaquance of):

c.

Dua to (or as a consaquance of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in the undarlying causa givan in Part I.

SICKLE CELL DISEASE

FULMINANT HEPATIC FAILURE

23b. Did tobacco use contribute to tha cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy parformed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to compiation of causa of death? 1 [ ] Yas 2 [X] No

25. Was cesa rafarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath *(Check only ona)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Phyaician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha ceuse(s) and manner statad.

29b. Signatura and titla of certifiar: Jayh A. Sohn

29c. Licansa number: RES-000

29d. Data signed *(Month, Day, Yaar)*: 9/27/97

30. Nama and addrass of parson who complatad ceusa of daath (Item 23a) (Type, Print): Taylor A. Sohn 600 N. Wolfe St, Baltimore, MD 21287-9106

State Registrar

31. Data filed *(Month, Day, Yaar)*: SEP 29 1997

32. Registrar's Signatura: John Thurlow Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31038

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sandra Marie Darby
2. Date of Death: Month 09 Day 25 Year 97
3. Time of Death: 5:15 PM
4a. Facility Name (If not institution, give street and number): Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 123-42-3544
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-25-51
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5003 Leejay Drive
10f. Zip Code: 20743
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Nurse
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Johnnie W. Frieison
18. Mother's Name (First, Middle, Maiden Surname): Dorothy M. Carter

19a. Informant's Name/Reletionship (Type, Print): Charlina Watson-Bethea/Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 270 Possum Court, Capitol Heights, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 9/30/97
20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licansee: ▶ Nancy A. Percentie
22. Name and Address of Facility: J. B. Jenkins Funeral Home, 7474 Landover Road, Landover, Maryland 20785

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finai disease or condition resulting in death) a.	Upper Gastrointestinal Bleeding	2 Days
Due to (or as a consequence of): b.	END STAGE LIVER DISEASE	> 1 year
Sequentially list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coagulopathy, encephalopathy, Metabolic Acidosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred st the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Steph Katz MD
29c. License number: D38687
29d. Date signed (Month, Day, Year): 09/26/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): PGHC, Cheverly MD, 20785 STEPHEN S KATZ, M.D

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Blackson-Kendall

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31039

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dolly Beatrice Dorsey

2. Date of Death — Month: 09 Day: 30 Year: 97

3. Time of Death: 8:35 PM

4a. Facility Name *(If not Institution, give street and number)*: Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-30-4836

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 02-28-11

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11800 Duckettown Road

10f. Zip Code: 20719

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic Worker

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Edward Brooks

18. Mother's Name *(First, Middle, Maiden Surname)*: Matilda Allen

19a. Informant's Name/Relationship *(Type, Print)*: Monroe Dorsey/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11812 Duckettown Road, Bowie, Maryland 20719

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial Park

Date: 10/6/97

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: ▶ Charles F. Bowman

22. Name and Address of Facility: J. B. Jenkins Funeral Home 7474 Landover road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Right Lower Lobe Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Urinary Tract Infection

Due to (or as a consequence of):

c. Breast Cancer

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? No AUTOPSY! (per family) 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Karl Terwilliger M.D.

29c. License number: D45967

29d. Date signed *(Month, Day, Year)*: 9-30-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Karl Terwilliger Prince George's Hospital Cheverly, MD

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: ▶ Julia Gardner Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31040

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Dora B. Dewar

2. Dete of Deeth — Month: September Dey: 25 Year: 1997

3. Time of Deeth: 7:25 PM

4a. Facility Neme *(If not institution, give street end number)*: Doctors Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 036-09-2378

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Feb. 7, 1912

9. Birthplace *(State or Foreign Country)*: West Virginia

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: P.G.

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 5704 Tennyson St.

10f. Zip Code: 20737

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexlcan, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+): ------

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Head Hostess

16b. Kind of Business/Industry: Private Men's Club Association

17. Fether's Neme *(First, Middle, Last)*: Charler L. Gainor

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Nora Helmick

19e. Informent's Neme/Relationshlp *(Type, Print)*: Betty L. Taylor (Daughter)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5704 Tennyson St. Riverdale, Md. 20737

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Chambers Crematory

Dete: 9/27/97

20c. Location - City or Town, Stete: Riverdale, Md.

21. Signeture of Funerel Servlce Licensee: Thomas S. Chamberlain # 670

22. Neme end Address of Feclility: Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737

To Be Completed by Funeral Director

DORA DEWAR

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. — Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death): e. Cardiac Arrest

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last:

b. Cardiomyopathy — 20 years

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other signiflcent condltions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

28. Plece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier

29c. License number: D20643

29d. Dete signed *(Month, Dey, Year)*: September 26, 1997

30. Neme and eddress of person who completed cause of death (item 23e) (Type, Print): Joseph Vaughn, MD 6492 Landover Road, Cheverly, MD 20785

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

State Registrar

31. Dete filed *(Month, Dey, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31041

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rudolph Theodore Danstedt, Jr.
2. Date of Death (Month, Day, Year): September 28, 1997
3. Time of Death: 10:30 PM
4a. Facility Name (If not institution, give street and number): Potomac Valley Nursing & Wellness Center
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-40-5967
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 4, 1941
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4757 Chevy Chase Drive, Apt. 209
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Programmer
16b. Kind of Business/Industry: Computer

17. Father's Name (First, Middle, Last): Rudolph Theodore Danstedt, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Edith Holmstrom

19a. Informant's Name/Relationship (Type, Print): Beth Tomasello Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 519 Calvin Lane, Rockville, Maryland 20851

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 9-29-97
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Mark I. Rapp
22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cancer of Tongue — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Walter Goozh, MD
29c. License number: D01120
29d. Date signed (Month, Day, Year): September 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Walter Goozh, MD 1299 Lamberton Drive, Silver Spring, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997
32. Registrar's Signature: Lia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

97-5579-031

VIVIAN ELLIOTT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31042

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIVIAN ELLIOTT
2. Date of Death (Month, Day, Year): SEPTEMBER 29 1997
3. Time of Death: 2:22 PM
4a. Facility Name *(If not institution, give street and number)*: WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 229-74-9913
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 26, 1950
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7333 New Hampshire Avenue, #903
10f. Zip Code: 20783
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Production Control Analyst
16b. Kind of Business/Industry: GEICO

17. Father's Name *(First, Middle, Last)*: Unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: MAry Thomas

19a. Informant's Name/Relationship *(Type, Print)*: Michelle E. Brown - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7333 New Hampshire Ave. #903, Hyattsville, MD 20783

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Thomas Family Cemetery
Date: 10-4-97
20c. Location - City or Town, State: Martinsville, VA

21. Signature of Funeral Service Licensee: J. T. Marshall
22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary Emboli

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Clarion Locke MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: SEPTEMBER 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CLARION LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrar's Signature: Clarion Locke MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31043

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEO ELLIS

2. Date of Death Month / Day / Year: SEPTEMBER 27, 1997

3. Time of Death: 9:02 AM

4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 537-22-1488

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sep. 12, 1918

9. Birthplace *(State or Foreign Country)*: Central Amer.

Usual Residence of Decedent

10a. State: MD.

10b. County: Prince George

10c. City, Town or Location: Landover

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7238 Landover Road #C

10f. Zip Code: 20785

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No *Specify:* Honduran

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Merchant Seaman

16b. Kind of Business/Industry: Private Industry

17. Father's Name *(First, Middle, Last)*: Lavorio Ellis

18. Mother's Name *(First, Middle, Maiden Surname)*: Leona Martinez

19a. Informant's Name/Relationship *(Type, Print)*: Melo Summers - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7238 Landover Road, #C, Landover, MD 20785

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 10/6/97

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: R. N. Horton

22. Name and Address of Facility: R. N. Horton C. Morticians, Inc. 600 Kennedy Street, N. W., DC, 20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CANCER OF PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: DME D33954

29d. Date signed *(Month, Day, Year)*: 9-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31044

Physician /Medical Examiner

1. Decadant's Name (First, Middla, Last): GERTRUDE O. EPSTEIN
2. Data of Daath — Month: SEPTEMBER Day: 26, Year: 1997
3. Tima of Death: 9:30 PM
4a. Facility Nama (If not institution, giva street and number): MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 056-10-4519
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 87 Yrs. — If Under 1 Yaar: Months / Days — If Undar 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): AUG. 3, 1910
9. Birthplaca (Stata or Foraign Country): NEW YORK

Usual Rasidance of Decadant

10a. Stata: MARYLAND
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15300 PINE ORCHARD DRIVE #3B
10f. Zip Coda: 20906
10g. Citizan of What Country?: UNITED STATES

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decadant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Datas:
13. Was Decadant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, etc. Specify: WHITE

15. Dacadant's Education (Specify only highast grada complatad) — Elamantary/Sacondary (0-12): — Collaga (1-4or 5+): 2
16a. Decadent's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): MOTION PICTURE BOOKER
16b. Kind of Business/Industry: THEATRE

17. Fathar's Nama (First, Middla, Last): MAX ORNSTEIN
18. Mothar's Nama (First, Middla, Maidan Sumama): SARAH RUTH FISCHER

19a. Informant's Name/Ralationship (Type, Print): MILDRED GOLDBLATT/SISTER
19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda): 385 EAST 16TH STREET, BROOKLYN, NEW YORK 11226

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☒ Ramoval from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar place): MT. ARARAT CEMETERY — Data: 9/29/97
20c. Location - City or Town, Stata: FARMINGDALE, NEW YORK

21. Signature of Funeral Service Licensee: Frank Astone
22. Nama and Addrass of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona causa on aach lina.

		Approximata Interval Between Onset and Death
Immediata Causa (Final disaase or condition rasulting in daath) a.	Ventricular Fibrillation	Immediate
Dua to (or as a consaquance of): b.	Myocardial Infarction	7 days
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last — Dua to (or as a consaquanca of): c.	Pneumonia	8 days
d.		

Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part I.

Diabetes
Gastro-intestinal bleeding
Deep Vein Thrombosis

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No
26. Placa of Death (Check only ona) — Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 8☐ Othar (Specify)
27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Sulcida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar):
28b. Tima of Injury: — M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad: —
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify): —
28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata): —

29a. Cartifiar (Check only one): 1☒ Certifying Phyaician: To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: Ira Paul Kretting MD
29c. License number: D21435
29d. Data signed (Month, Day, Yaar): September 27, 1997

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): Ira Paul Kretting MD 2101 Medical Park Drive Silver Spring 20902

State Registrar

31. Data filed (Month, Day, Yaar): SEP 29 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Gertrude Epstein 9/26/97 F30

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31045

Amended #9, 9/30/97, JW, Mont. Cty.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Benjamin Everett

2. Dete of Deeth (Month, Dey, Yeer): September 26 1997

3. Time of Death: 1:07AM

4a. Fecility Neme (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Deeth: Laurel

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 458-20-2494

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): April 22, 1923

9. Birthplece (State or Foreign Country): ~~Dallax~~, TX Dallas

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Prince Georges

10c. City, Town or Location: Adelphi

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 10413 Glenmore Drive

10f. Zip Code: 20783

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1945-1966

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondery (0-12): College (1-4or 5+): 1

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Instrument Maker

16b. Kind of Business/Industry: United States Dept. of Agriculture

17. Fether's Neme (First, Middle, Last): Benjamin Leo Everett

18. Mother's Neme (First, Middle, Maiden Surneme): Olive King Everett

19a. Informent's Neme/Reletionship (Type, Print): Charlotte M. Everett/wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 10413 Glenmore Dr., Adelphi, MD 20783

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Maryland Vets. Cem.

Dete: 10/2/97

20c. Locetion - City or Town, Stete: Cheltenham, MD

21. Signeture of Funerel Service Licensee: Dennis F. Holland

22. Neme end Address of Fecility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904

Physician /Medicai Examiner

23a. Part I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. Necrotizing pancreatitis. — Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last:

b. Sepsis — Due to (or es a consequence of):

c. Circulatory collapse. — Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

renal failure.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes cese referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [ ] Medical Examiner: On the besis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier:

29c. License number: D28759

29d. Dete signed (Month, Dey, Yeer): 9/26/97

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): B. BAHMANYAR MD 7311 Hanover Parkway Greenbelt MD 20770

State Registrar

31. Dete filed (Month, Dey, Yeer): SEP 3 0 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James A Finley Sr.

2. Date of Death: Month 09 Day 19 Year 97

3. Time of Death: 18:32

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL CENTER

4b. City, Town, or Location of Death: BALTIMORE, MD

4c. County of Death:

Funeral Director

5. Social Security Number: 229-26-3063

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 15, 1925

9. Birthplace (State or Foreign Country): WEST VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: DORCHESTER

10c. City, Town or Location: HURLOCK

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 6302 BURFORD LANE

10f. Zip Code: 21643

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE WELDER

16b. Kind of Business/Industry: MANUFACTURING

17. Father's Name (First, Middle, Last): JAMES ARNETT FINLEY

18. Mother's Name (First, Middle, Maiden Surname): VETA FORD

19a. Informant's Name/Relationship (Type, Print): JAMES A. FINLEY, JR./SON

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 447 JOHN OWINGS ROAD, WESTMINSTER, MD 21158

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD EASTERN SHORE VET.CEM.

Date: 9/24/97

20c. Location - City or Town, State: BEULAH, MARYLAND

21. Signature of Funeral Service Licensee: Samuel D Zeller

22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Borchelt

29c. License number: D 44498

29d. Date signed (Month, Day, Year): 09/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRET BORCHELT, MD 22 S. GREENE ST. BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT - 7 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

97-5522-033
AM
NICHOLAS
FOGG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31047

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NICHOLAS DOMINIQUE FOGG
2. Date of Death (Month, Dey, Year): SEPTEMBER 27,1997
3. Time of Death: 0608 A
4a. Facility Name *(If not institution, give street and number)*: FORT WASHINGTON HOSPITAL
4b. City, Town, or Location of Death: FT. WASHINGTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 212-19-7188
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 17 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 9-8-80
9. Birthpiece *(State or Foreign Country)*: WASHINGTON DC

Usual Residence of Decedent

10a. Stete: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: FT. WASHINGTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12509 PARKTON ST.
10f. Zip Code: 20744
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Eduction *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STUDENT
16b. Kind of Business/Industry: HIGH SCHOOL

17. Father's Name *(First, Middle, Last)*: JOSEPH A. FOGG SR.
18. Mother's Name *(First, Middle, Meiden Surname)*: DEBORAH BROOKS

19a. Informant's Neme/Reiationship *(Type, Print)*: JOSEPH A. FOGG SR.
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 12509 PARKTON ST. FT. WASHINGTON MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: MD VETERANS - CHELTENHAM | Date: 10-1-97
20c. Locetion - City or Town, Stete: CHELTENHAM MD

21. Signature of Funerei Service Licensee: ▶ Alex S. Pope Jr.
22. Name and Address of Feciility: POPE FUNERAL HOME 2617 PENN AVE. WASHINGTON DC 20020

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	e. Chest Injuries	
	Due to (or es a consequence of):	
Sequentieily list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☒ Yes 2☐ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Neturei 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*: 9-27-97
28b. Time of Injury: 0500 M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Passenger, MV auto accident
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*: STREET
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*: 3000 Blk. Tucker Rd

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.
29b. Signeture end title of certifier: ▶ [signature]
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: SEPTEMBER 28,1997
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: SEP 30 1997
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31048

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Angela M. Fernandez
2. Date of Death Month Day Year: Sept. 28, 1997
3. Time of Death: 10:20 AM
4a. Facility Name *(If not institution, give street and number)*: Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 546-53-4736
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 2, 1915
9. Birthplace *(State or Foreign Country)*: Philippines

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6513 Bock Rd.
10f. Zip Code: 20745
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Filipino

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: At Home

17. Father's Name *(First, Middle, Last)*: Emiterio Mangila
18. Mother's Name *(First, Middle, Maiden Surname)*: Modesta Ramos

19a. Informant's Name/Relationship *(Type, Print)*: Mercy Fernandez/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: 10/4/97
20c. Location - City or Town, State: Clinton, Md.

21. Signature of Funeral Service Licensee: George P. Kalas Jr.
22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Uro sepsis
Osteoarthritis
Cerebral Vascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D37066
29d. Date signed *(Month, Day, Year)*: 09-29-97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Uchechi T. Opaigbeogu, M.D. 4467 Old Branch Ave. #105, Temple Hills, MD 20748

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: Judi Sheridan Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Angela Mangila Fernandez
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31049

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elipaz E. Flores

2. Date of Death Month Day Year: September 30, 1997

3. Time of Death: 11:30P.M.

4a. Facility Name *(If not institution, give street and number)*: Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: N/A

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1920

9. Birthplace *(State or Foreign Country)*: Philippine Is.

Usual Residence of Decedent

10a. State: N/A

10b. County: N/A

10c. City, Town or Location: Binan, Laguna, Philippine Islands

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 405 Dela Paz

10f. Zip Code: N/A

10g. Citizen of What Country?: Philippine Is.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Filipino

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales person

16b. Kind of Business/Industry: Retail

17. Father's Name *(First, Middle, Last)*: Fernando Espeleta

18. Mother's Name *(First, Middle, Maiden Surname)*: Leonila Vierneza

19a. Informant's Name/Relationship *(Type, Print)*: Claudio A. Flores/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 405 Dela Paz, Binan, Laguna, Philippine Is.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Eternal Gardens — Date: 10/11/97

20c. Location - City or Town, State: Binan, Laguna, P.Is.

21. Signature of Funeral Service Licensee: George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Keith Banton, MD

29c. License number: D36562

29d. Date signed *(Month, Day, Year)*: 10/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Keith B. Banton, M.D. 1328 Southern Ave., S. E. #300, Washington, D.C. 20032

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Brayboy-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31050

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSA L. FLORES
2. Date of Death Month Day Year: Sept 30 1997
3. Time of Death: 6:18 pm
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216-15-6323
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 21 62
9. Birthplace (State or Foreign Country): GUATEMALA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: GERMANTOWN
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13030 TRAILSIDE WAY
10f. Zip Code: 20874
10g. Citizen of What Country?: GUATEMALA CITY

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: GUATEMALA
14. Race - American Indian, Black, White, etc. Specify: HISPANIC

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK
16b. Kind of Business/Industry: THE PRUITT COMPANY

17. Father's Name (First, Middle, Last): ANTONIO DeLCID
18. Mother's Name (First, Middle, Maiden Surname): ROSA ABULARCH

19a. Informant's Name/Relationship (Type, Print): ISMAEL FLORES-HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13030 TRAILSIDE WAY, GERMANTOWN, MD 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FAMILY CEMETERY
Date: OCT. 7 97
20c. Location - City or Town, State: GUATEMALA CITY

21. Signature of Funeral Service Licensee: ▶ W H Bacon 276
22. Name and Address of Facility: W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, NW WASHINGTON, D.C. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE PROMYLOCYTIC Lukemia — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last:
b.
Due to (or as a consequance of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S Bchdmm MD
29c. License number: D0052045
29d. Date signed (Month, Day, Year): Sept 30-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SARDAR BA HADUR 1500 Forest Glen Rd. Silver Spr. Md. 20910

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997
32. Registrar's Signature: ▶ Glen Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31051

Amended #24A 10-02-97 PGCHD ELM

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JOYCE M. FRAGER	September 25, 1997	10:44 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PRINCE GEORGES HOSPITAL CENTER	CHEVERLY	PRINCE GEORGE'S

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
579-66-5120	1☐ M 2☒ F	46 Yrs.			July 31, 1951	Roanoke, VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince George's	District Heights	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1901 Addison Road, South	20747	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: African American

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Nursing Asst.	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Roy Starkey	Marie Lockett

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kershaw Frager - Husband	1901 Addison Road, South, District Heights, MD 20747

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Lincoln Memorial Cemetery	10/3/97	Suitland, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John T. Stewart III	STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Mobid Hypertension

Due to (or as a consequence of):
Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Congestive Heart Failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	NA	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Sandra Robinson-Redway MD	D 32519	10/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type/Print)
SANDRA ROBINSON-REDWAY 3311 TOLEDO TERR. C202 HYATTSVILLE MD 20782

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

6

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 02 1997	[illegible]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31052

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Wilbur Floyd
2. Date of Death Month Day Year: September 29, 1997
3. Time of Death: 9:55 AM
4a. Facility Name *(If not institution, give street and number)*: Hillhaven Nursing Center, Inc.
4b. City, Town, or Location of Death: Adelphi
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 195-07-5186
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 24, 1909
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: PA
10b. County: Dauphin
10c. City, Town or Location: Harrisburg
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 624 Wilhelm Road #60
10f. Zip Code: 17111
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman
16b. Kind of Business/Industry: Automobile

17. Father's Name *(First, Middle, Last)*: Samuel A. Floyd
18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Reist

19a. Informant's Name/Relationship *(Type, Print)*: Barbara H. Fryer
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9204 Dewberry Lane, College Park, MD 20740

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☒Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cocklin Cemetery — Date: 10/4/97
20c. Location - City or Town, State: Dillsburg, PA

21. Signature of Funeral Service Licensee: Steven D Strand
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Multiple Strokes — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles M Benner
29c. License number: D31563
29d. Date signed *(Month, Day, Year)*: September 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Charles M. Benner, M.D. 11251 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31053

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOEL H. FISHER
2. Date of Death Month: SEPT Day: 27 Year: 1997
3. Time of Death: 5.10 PM.
4a. Facility Name (If not institution, give street and number): LEVINDALE HEBREW NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 055--07--9682
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 28,1918
9. Birthplace (State or Foreign Country): NEW YORK, NY

Usual Residence of Decedent

10a. State: D.C.
10b. County: N/A
10c. City, Town or Location: WASHINGTON, D.C.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 800 25TH STREET, N.W.
10f. Zip Code: 20037
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 5+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ATTORNEY
16b. Kind of Business/Industry: LAW
17. Father's Name (First, Middle, Last): SAMUEL FISHER
18. Mother's Name (First, Middle, Maiden Surname): JEANNETTE ALMOUR
19a. Informant's Name/Relationship (Type, Print): SUSAN FISHER SULLAM DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5707 OAKSHIRE ROAD, BALTIMORE, MD 21209
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT COMFORT CREMATORY
Date: 10/1/97
20c. Location - City or Town, State: ALEXANDRIA, VIRGINIA
21. Signature of Funeral Service License: Jeffrey C. Pa
22. Name and Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 WI AVENUE, N.W. WASHINGTON, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MULTI SYSTEM FAILURE — 3 MONTHS
Due to (or as a consequence of): b. SENILE DEMENTIA. — YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CANCER PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ATTENDING PHYSICIAN — Seg Gawler
29c. License number: D 25610
29d. Date signed (Month, Day, Year): SEPT. 28. 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SET HTWAR LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MARYLAND 21215

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-5749-025

MARY GARRETT

Items:23a part I,27 per MEO G-754 12/10/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31054

Reg. No.

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: MARY FRANCES GARRETT

2. Date of Death: Month OCTOBER Day 7, Year 1997

3. Time of Death: 8:18A.M.

4e. Facility Name *(If not institution, give street and number)*: HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: HAVRE DE GRACE

4c. County of Death: HARFORD COUNTY

Funeral Director

5. Social Security Number: 217-49-6727

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months 5 Days 4; If Under 24 Hrs. Hours Min.

8. Date of Birth *(Month, Day, Year)*: May 3, 1997

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 615 Edmund St.

10f. Zip Code: 21001

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowad 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, atc. *Specify:* White

15. Dacedant's Educetion *(Specify only highest grade completed)*: Elemantary/Sacondary (0-12) 0; Collaga (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Infant

16b. Kind of Businass/Industry: ---

17. Fether's Name *(First, Middle, Last)*: Bobby Junior Garrett

18. Mother's Name *(First, Middle, Maiden Surname)*: April Joy Rembold

19a. Informant's Name/Relationship *(Type, Print)*: Bobby J. Garrett - father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 615 Edmund St., Aberdeen, Md. 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Carmel Cemetery

Dete: 10-10-97

20c. Location - City or Town, State: Emmorton, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Hughes

22. Name end Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad the deeth. Do not antar the moda of dying, such as cerdiac or respiratory errest, shock, or heert feilure. List only one causa on each line.

Approximata Intarval Between Onset end Deeth

Immediata Cause (Final diseasa or condition resulting in deeth) a. REACTIVE AIRWAY DISEASE

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was casa referred to medical examiner? 1☒ Yes 2☐ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datermined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Steta)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurrad et tha time, date and placa, and due to the ceuse(s) end manner as stated. 2☒ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurred et tha tima, data end place, and dua to tha ceuse(s) and menner stated.

29b. Signature and title of certifier: Theodore M. King MD

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: OCTOBER 8, 1997

30. Name and address of person who complatad cause of daeth (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Yaar)*: OCT 15 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31055

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sterling Lewis Green

2. Date of Death (Month, Day, Year): Sept 25, 1997

3. Time of Death: 8:10 PM

4a. Facility Name (If not institution, give street and number): 1717 Emory Road

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-12-5394

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 6, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1717 Emory Road

10f. Zip Code: 21136

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WW II

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chauffeur

16b. Kind of Business/Industry: Black & Decker

17. Father's Name (First, Middle, Last): William L. Green

18. Mother's Name (First, Middle, Maiden Surname): Beulah Raver

19a. Informant's Neme/Relationship (Type, Print): Shirlee Elseroad, daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1717 Emory Road, Reisterstown, MD 21136

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): Emory Cemetery

Date: 9/29

20c. Location - City or Town, State: Upperco, MD

21. Signeture of Funeral Service Licensee: ▶ Steven W. Eline

22. Name end Address of Facility: Eline Funeral Home, 934 south Main St, Hampstead, Md 21074

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): e. RESPIRATORY Failure — 1 Month

Due to (or as a consequence of): COPD — 1990

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other signiticant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

CHD
CHF
CA Prostate

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☐ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D18099

29d. Date signed (Month, Dey, Year): 9-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Maria Stella P.O Box 591 Westminster, Md

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: ▶ Julie Drucker Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97 31056

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAZEL KEZIAH GREEN			2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 27 1997	3. TIME OF DEATH: 10-45A M
4. SOCIAL SECURITY NUMBER: 213343992	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11-14-13	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): CARROLL Co. General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 1442 Buckhorn Rd.		10f. ZIP CODE: 21784	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): farmer	16b. KIND OF BUSINESS/INDUSTRY: agriculture	
17. FATHER'S NAME (First, Middle, Last): Thomas Milton Flater Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Airy Goldie Barnes	
19a. INFORMANT'S NAME (Type/Print): Joseph Green Jr. - son		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 845, Mt. Airy, MD 21771-0845	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Providence Cemetery 9/29/97 DATE	20c. LOCATION — City or Town, State: Gamber, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Katherine Pritts-Sweitzer		22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	3 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION
MYELOPROLIFERATIVE DISORDER

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D 46962	29d. DATE SIGNED (Month, Day, Year): ▶ SEPTEMBER 27, 1997	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. SHIRAZI, M.D. CARROLL COUNTY GENERAL HOSPITAL, WESTMINSTER			
31. DATE FILED (Month, Day, Year): SEP 29 1997	32. REGISTRAR'S SIGNATURE: Julia Hardesty Randall		

OHMH-18 Rev 1/89

9726801237 UNIT # 07-01-21
GREEN,HAZEL KEZIAH
156-A GALVIN,THOMAS K
11/14/1913 F 09/25/97
INP

WRC
97-5538-031

GEORGE W. GATLING

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31057

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE W. GATLING, JR.

2. Date of Death (Month, Day, Year): SEPT. 28, 1997

3. Time of Death: 1:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: 2504 SPENCER RD.

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 237-62-9929

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 11, 1934

9. Birthplace *(State or Foreign Country)*: Northampton Co.,NC

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 913 Varnum Street, N. E.

10f. Zip Code: 20017

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 7/13/53 - 7/12/56

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired General Engineer

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: George W. Gatling, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Izula Cumbo

19a. Informant's Name/Relationship *(Type, Print)*: Anna E. Gatling - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 913 Varnum Street, N. E.,Washington, D.C. 20017

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gatling Family Cemetery

Date: 10/6/97

20c. Location - City or Town, State: Conway, N.C.

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E.,Washington, D. C.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 9558

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic cardiovascular disease

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Partial 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: SEPT. 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Thompson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31058

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel C. Guthrie

2. Date of Death (Month, Day, Year): Sept. 27 1997

3. Time of Death: 6:45 A.M.

4a. Facility Name (If not institution, give street and number): 12217 Westmont Lane

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577 22 9700

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28, 1912

9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12217 Westmont Lane

10f. Zip Code: 20715

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookbinder

16b. Kind of Business/Industry: Print Shop

17. Father's Name (First, Middle, Last): John Osborne

18. Mother's Name (First, Middle, Maiden Surname): Clara Jones

19a. Informant's Neme/Relationship (Type, Print): Juanita G. Paterno daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 12217 Westmont Lane Bowie Maryland 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery

Date: Sept. 30, 1997

20c. Location - City or Town, State: Brentwood Maryland

21. Signature of Funeral Service Licensee: Michael L Burton

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death)

a. Alzheimer's Disease — 5 yrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Pneumonia — 1 wk.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one)

Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as steted.
2☐ **Medicaf Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number: DS 4403

29d. Date signed (Month, Day, Year): 9/30/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Dubey MD 3431 Superior Ln Bowie MD 20715.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

(6)

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Mary Gallagher

2. Date of Death (Month, Day, Year): September 25, 1997

3. Time of Death: 4:30 pm

4a. Facility Name (If not institution, give street and number): Doctors' Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 026 12 9542

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1924

9. Birthplace (State or Foreign Country): Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2607 Kenway Lane

10f. Zip Code: 20715

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward J. Ledvina

18. Mother's Name (First, Middle, Maiden Surname): Mary C. Sylvia

19a. Informant's Name/Relationship (Type, Print): Raymond Gallagher Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2607 Kenway Lane Bowie Maryland 20715

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery Date: Sept. 29, 1997

20c. Location - City or Town, State: Crownsville Md.

21. Signature of Funeral Service Licensee: Michael L Sigler

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTI ORGAN FAILURE — 1 wk

Due to (or as a consequence of):

b. SYSTEMIC LUPUS ERYTHEMATOSUS — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SMALL BOWEL OBSTRUCTION

SEPSIS

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

26d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gram. MD ATTENDING

29c. License number: D16197

29d. Date signed (Month, Day, Year): 9-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDRES C. LARA, MD - 9326 LANHAM-SEVERN RD. LANHAM MD 20706

State Registrar

31. Data filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Sheridan Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Elizabeth Mary Gallagher

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Ann Galloway
2. Date of Death Month Day Year: September 30, 1997
3. Time of Death: 8:15 AM
4a. Facility Name (If not institution, give street and number): 3809 Oaklawn Rd.
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-56-5262
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 5, 1943
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3809 Oaklawn Rd.
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Deli Manager
16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): James Jenkins
18. Mother's Name (First, Middle, Maiden Surname): Carrie Pugh

19a. Informant's Name/Relationship (Type, Print): Jerry A. Galloway/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as item 10

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Arlington National Cem. Date: 10/7/97
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sudden cardiac death (arrhythmia probable)	immediate
Dua to (or as a consequance of): b.	rheumatic heart disease	30+ yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Dua to (or as a consequance of): c.	rheumatic fever	45 yrs
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Laura A Donegan MD
29c. License number: Pennsylvania MD-059649-L
29d. Date signed (Month, Day, Year): Sept 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Laura A. Donegan, Malcolm Grow Med Ctr., 1050 W. Perimeter Rd, Andrews AFB, MD 20762

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julie Sheridan-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

97-5512-033
DOMINICK GARDNER
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31061

Items:23a part I,27 per MEO G-752 10/22/97 dh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dominick F. Gardner

2. Date of Death (Month, Day, Year): SEPT. 27, 1997

3. Time of Death: 0345AM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER E.R.

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: None

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday) Yrs.: | If Under 1 Year: Months 9, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 3/10/97

9. Birthplace (State or Foreign Country): Cheverly,Md.

Usual Residance of Dacedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3406 Dodge Park Rd. # 201

10f. Zip Code: 20785

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: None

17. Fathar's Name (First, Middle, Last): Dante F. Gardner

18. Mothar's Name (First, Middle, Maiden Surnama): Diane C. Berry

19a. Informant's Name/Ralationship (Type, Print): Diane C. Berry/Mother

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): Same as # 10 above

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Nama of cematary, cremetory or other place): Harmony Mem. Park | Date: 10/7/97

20c. Location - City or Town, State: Landover,Md.

21. Signature of Funeral Service Licensee: ▶ Darry W. Pratt

22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that causad the daath. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each lina.

Approximate Interval Batwaan Onsat and Daath

Immediate Causa (Final diseasa or condition resulting in death)
a. SUDDEN INFANT DEATH SYNDROME (SIDS)

Due to (or as e consequence of):

Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☒ Yes 2☐ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residanca 6☐ Other (Specify)

27. Manner of Death: ☒ 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☐ **Certifying Physician:** To tha bast of my knowladge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated. ☒ **Medical Examiner:** On tha basis of examination and/or investigation, In my opinion, death occurred at the time, data and placa, and due to tha causa(s) and manner stated.

29b. Signature and title of certifiar: ▶ Marvin M. Hull

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): SEPT. 27, 1997

30. Name and address of parson who complated cause of daath (Item 23a) (Type, Print): MARYANN A. KOSTELNY 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yaar): OCT 06 1997

32. Registrar's Signature: Julie Davidson Rankin

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31062

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KERMIT GLEATON

2. Date of Death Month: SEPT Day: 30 Year: 1997

3. Time of Death: 10:50 AM

4a. Facility Name *(If not Institution, give street and number)*: 8715 1ST AVE APT. 801D

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-76-2671

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 44 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6-18-1953

9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10a. State: MD

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 8715 FIRST STREET, #801-D

10f. Zip Code: 20912

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: UNEMPLOYED

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: KERMIT GLEATON, SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY McDANIEL

19a. Informant's Name/Relationship *(Type, Print)*: LAWRENCE McDANIEL- BROTHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3635 WARDER STREET, NW WASHINGTON, DC 20010

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD NATIONAL CEMETERY

Date: 10-9-97

20c. Location - City or Town, State: LAUREL, MD

21. Signature of Funeral Service Licensee: B. C. Taylor

22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death: MINUTES

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D23540

29d. Date signed *(Month, Day, Year)*: 9/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HUGH HILL MD 6915 RAGNOR RD BETHESDA MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 10 1997

32. Registrar's Signature: Judi Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

97-5545-031
ML

STEVEN C. GREBE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stephen C. Grebe
2. Date of Death (Month, Day, Year): SEPTEMBER 29 1997
3. Time of Death: 4:08 AM
4a. Facility Name (If not institution, give street and number): 8804 RIDGE ROAD
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 053-38-1553
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 15, 1945
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8804 Ridge Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Professor
16b. Kind of Business/Industry: American University

17. Father's Name (First, Middle, Last): Frank Grebe
18. Mother's Name (First, Middle, Maiden Surname): Sylvia Thresher

19a. Informant's Name/Relationship (Type, Print): Sharon M. Pickett/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8804 Ridge Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: October 1, 1997
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Michael S. Hagan M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic cardiovascular disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? Partial 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): SEPTEMBER 29, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31064

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Amalia Dolores Gonzalez-Barreras

2. Date of Death Month Day Year: September 29, 1997

3. Time of Death: 12:50AM

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-80-7653

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 29, 1911

9. Birthplace *(State or Foreign Country)*: Cuba

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9219 East Parkhill Drive

10f. Zip Code: 20814

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No *Specify:* Cuban

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Volunteer Work

17. Father's Name *(First, Middle, Last)*: Luis Sanchez

18. Mother's Name *(First, Middle, Meiden Surneme)*: Lucia Cortina

19a. tnformant's Name/Relationship *(Type, Print)*: Amalina Nisos / daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9219 East Parkhill Drive, Bethesda, Maryland 20814

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Pleca of Disposition *(Neme of cemetery, cremetory or other pleca)*: Montgomery Crematorium, Inc. Dete: September 30, 1997

20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signeture of Funeral Servica Licensee: Barbara J. McMullen Lawrence M00831

22. Name end Address of Facility: Robert A. Pumphrey Funeral Home / Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

a. End Stage Renal Disease — 4 1/2 years

Due to (or es e coqsequence of):

b. Hypertension — 4 1/2 years

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other atgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Stroke, Anemia, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifytng Phyelcian**: To the best of my knowledge, death occurred et the time, date end placa, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: James Knepshield, MD

29c. License number: D04525

29d. Date signed *(Month, Dey, Year)*: 29 Sep 97

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): James Knepshield, M.D. 4915 Hobson Ave Bethesda, md 20814

State Registrar

31. Date filed *(Month, Dey, Yeer)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

AMALIA GONZALEZ SEPT 29 1997 12:50 P.M.

Division of Vital Records, P.O. Box 68760,

97 31065

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ETTA GLAZER			2. DATE OF DEATH (Month, Day, Year): SEPTEMBER 26 1997	3. TIME OF DEATH: 10.50 AM
4. SOCIAL SECURITY NUMBER: 029-03-4319	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT, 11, 1913	8. BIRTHPLACE (State or Foreign Country): MASS.
9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8811 COLESVILLE RD. #615		10f. ZIP CODE: 20910	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PERSONNEL SPECIALIST	16b. KIND OF BUSINESS/INDUSTRY: U.S. GOV'T.	
17. FATHER'S NAME (First, Middle, Last): LOUIS GLAZER		18. MOTHER'S NAME (First, Middle, Maiden Surname): TILLIE SCHILLER	
19a. INFORMANT'S NAME (Type/Print): CHARLES H. GLAZER/BROTHER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 FORSTON ST., TAKOMA PARK, MD.20912	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CHAMBERS CREMATORY DATE: 9/27/97	20c. LOCATION — City or Town, State: RIVERDALE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.W. Chambers M00091		22. NAME AND ADDRESS OF FACILITY: CHAMBERS FUNERAL HOMES, P.A. SILVER SPRING, MD. 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such aa cardiac or reapiratory arreat, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. CARDIAC ARRYTHMIAS — Approximate Interval Between Onset and Death: MINUTES

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PAROXYSMAL ATRIAL TACHYCARDIA
UNSPECIFIED DISEASE OF PERICARDIUM

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: P. Talwar, MD.	29c. LICENSE NUMBER: D 36552	29d. DATE SIGNED (Month, Day, Year): SEPTEMBER 26 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. TALWAR, 6121 MONTROSE RD. ROCKVILLE MD. 20852

31. DATE FILED (Month, Day, Year): SEP 30 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICK GERITY

2. Date of Death: Month: September Day: 27 Year: 1997

3. Time of Death: 6:50 A.M.

4a. Facility Name (If not institution, give street end number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 286-01-7517

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 17, 1919

9. Birthplace (State or Foreign Country): Cleveland, Ohio

Usual Residence of Decedent

10a. State: Ohio

10b. County: Cuyahoga

10c. City, Town or Location: Bay Village

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street end Number: 29100 Osborne Road

10f. Zip Code: 44140

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 12/5/42 - 10/28/43

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American indien, Bleck, White, etc. Specify: White

15. Decedent's Edecetion (Specify only highest grade completed): Elementery/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief of Police

16b. Kind of Business/Industry: Law Enforcement

17. Father's Name (First, Middle, Last): John Gerity

18. Mother's Neme (First, Middle, Meiden Surneme): Mary O'Malley

19a. Informent's Name/Reletionship (Type, Print): Mary Hervey (Daughter)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 112 Kendrick Place #34, Gaithersburg, MD 20878

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Remeval from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Holy Cross Cemetery

Dete: 10/1/97

20c. Location - City or Town, Stete: Cleveland, Ohio

21. Signature of Funeral Service Licensee: Mary M. Jui

22. Neme end Address of Feciliity: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Death
Immediete Ceuse (Finel disease or condition resulting in death)	e. Sepsis Syndrome	DAYS
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest	b. Pneumonia	DAYS
Due to (or es e consequence of):		
	c.	
Due to (or es e consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Renal failure

23b. Did tobacco use contribute to the cauee of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicel exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth (Check only one): Hospital: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 ☐ **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: Alan S Chanales MD

29c. License number: 29453

29d. Date signed (Month, Dey, Yeer): September 27, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): ALAN S. CHANALES 15225 SHADY GROVE RD ROCKVILLE MD 20850

State Registrar

31. Dete filed (Month, Day, Year): SEP 3 0 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31067

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LEOTIS GIVENS

2. Date of Death Month SEP Day 27 Year 1997

3. Time of Death: 4:50 AM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 334-30-1322

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 16, 1937

9. Birthplace *(State or Foreign Country)*: Mississippi

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 18619 Mallory Place

10f. Zip Code: 20879

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Medical Technologist

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: N.A. Givens

18. Mother's Name *(First, Middle, Maiden Surname)*: Jessie Mae Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Son Hui Givens (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18619 Mallory Place, Gaithersburg, MD 20879

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 9/29/97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Jerry M. Devol

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. UNCAL HERNIATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. SUBDURAL HEMATOMA

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John T. Schindler, M.D.

29c. License number: 18201 (WV)

29d. Date signed *(Month, Day, Year)*: 09/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOHN T. SCHINDLER, LT, MC, USN, NATIONAL NAVAL MEDICAL CENTER, BETHESDA MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31068

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jane E. Gatlin
2. Date of Death (Month, Day, Year): September 26, 1997
3. Time of Death: 7:55 PM
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-54-8533
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 11, 1923
9. Birthplace *(State or Foreign Country)*: Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5902 Walton Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry Talbot Gilmore
18. Mother's Name *(First, Middle, Maiden Surname)*: Mamie Leland Burdine

19a. Informant's Name/Relationship *(Type, Print)*: H. Grady Gatlin, Jr./Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5902 Walton Road, Bethesda, Maryland 20817

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery — Date: Sept. 30, 1997
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Michael P. Kuttle M00348
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Sepsis

Due to (or as a consequence of):

c. Necrotic Bowel

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ernest D. Hanowell

29c. License number: D21898

29d. Date signed *(Month, Day, Year)*: August 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ernest D. Hanowell, M.D., 6410 Rockledge Drive, #403, Bethesda, Maryland 20817

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31069

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT V. HEARN
2. Date of Death — Month: OCTOBER Day: 4 Year: 1997
3. Time of Death: 1010
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 216-40-4589
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 06/05/41
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Pittsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6140 Morris Road
10f. Zip Code: 21850
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer & Contractor
16b. Kind of Business/Industry: Poultry/Grain

17. Father's Name *(First, Middle, Last)*: George W. Hearn
18. Mother's Name *(First, Middle, Maiden Surname)*: Pauline Littleton

19a. Informant's Name/Relationship *(Type, Print)*: Pauline L. Hearn
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6140 Morris Rd., Pittsville, MD 21850

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Johns-Powellville — Date: 10-8
20c. Location - City or Town, State: Powellville, MD

21. Signature of Funeral Service Licensee: Michael T. Eskow
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home, PO Box 43, Federalsburg, MD 21632

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Liver Cirrosis. ~

Due to (or as a consequence of):
CHF ~

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: H50497
29d. Date signed *(Month, Day, Year)*: 10-6-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 108 Pine Bluff Rd Salisbury, MD 21801 Chris Snyder, D.O.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT - 7 1997
32. Registrar's Signature: Julia Knudsen-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Robert V. Hearn 216-40-4589

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31070

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Barbara Ann Forney Luis Harper

2. Date of Death Month Day Year: September 26, 1997

3. Time of Death: 9:05 a.m.

4a. Facility Name *(If not institution, give street and number)*: 12717 MacDuff Drive

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 287-22-5303

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 19, 1928

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residance of Decedant

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12717 MacDuff Drive

10f. Zip Coda: 20744

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Dacedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yeer or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2 years

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fathar's Name *(First, Middla, Last)*: Arthur Robert Luis

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Maybelle Grace Phillips

19a. Informant's Name/Ralationship *(Type, Print)*: Malcolm J.L. Harper - son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 2701 Park Center Dr. Alexandria, Va. 22302

20a. Mathod of Disposition: 1☐ Buriel 2☒ Cramation 3☐ Ramovel from Steta 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Nama of cematary, cramatory or othar place)*: Arlington Crematory

Data: 9-28

20c. Location - City or Town, Steta: Arlington Va.

21. Signature of Funeral Service Licensee: W.H. Bacon 226

22. Neme and Address of Facility: W.H. Bacon 3447 14th Street, NW Washington, D.C.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onset and Death

Immediata Causa (Final disease or condition rasulting in daath)

a. Ovarian Cancer

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

b.

Dua to (or as e consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undariying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarminad

28a. Date of Injury *(Month, Day Year)*: N/A

28b. Tima of Injury: N/A M

28c. Injury at Work? 1☐ Yas 2☐ No N/A

28d. Describe how injury occurred: NA

28e. Placa of Injury - At home, farm, strast, factory, office building, atc. *(Specify)*: NA

28f. Location *(Strast and Number or Rural Routa Number, City or Town, Stata)*: NA

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the cause(s) and manner stetad.

29b. Signature and titla of certifiar: Carl Johnson

29c. Licensa number: D45881

29d. Data signed *(Month, Day, Year)*: 9/26/97

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Type, Print): Carl Johnson 700 Old Line Center Waldorf MD 20601

State Registrar

31. Data filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Judy Strucker Randall

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Barbara Ann Forney Luis Harper

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:10a,b,c,e,f per Informant & F.H G-753 11/13/97 reb

Certificate of Death

Reg. No. 97 31071

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Last): Maude Judd Harris

2. Deta of Death: Month Sept. Day 25, Year 1997

3. Time of Death: 3:20am

4a. Facility Nema (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 243076407

6. Sax: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan.18,1912

9. Birthplace (State or Foraign Country): Sanford,N.C.

Usual Residance of Decedant: ~~4507 Sprucewood Court,Temple Hills, Md 20748~~

10a. Stata: N.CAROLINA ~~MD~~.

10b. County: ~~Prince~~ George's

10c. City, Town or Location: ~~Temple Hills~~ DURHAM, N.C

10d. Inside City Limits: ~~XX~~☒ Yas 2☐ No

10e. Street and Number: 1217 SEDGEFIELD ST. ~~4507 Sprucewood Court~~

10f. Zip Coda: ~~20748~~ 27705

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes ~~2☒~~ No. If Yas, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Black. Specify: American

15. Dacedent's Education (Specify only highast grada completed): Elamantary/Secondary (0-12) Secondary 10; Collaga (1-4or 5+)

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Homemaker

16b. Kind of Business/Industry: Housewife

17. Father's Nema (First, Middle, Last): William Judd

18. Mothar's Nama (First, Middle, Maidan Surnama): Maggie Judd

19a. Informant's Name/Ralationship (Type, Print): Lorrine Horner/Daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20748: 4507 Sprucewood Court,Temple Hills, MD.

20a. Mathod of Disposition: 1☐ Burial 2☐ Cremetion 3☒ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Beechwood Cemetery

Data: 10/3/97

20c. Location - City or Town, Stata: Durham, N.C.

21. Signature of Funaral Service Licensee: Charles C. Diggs Jr.

22. Neme and Address of Facility: 4906 Iverson Place, The House of Diggs Funerals, Temple Hills, Maryland 20748

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that causad the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

		Approximate Interval Between Onset and Death
Immediata Cause (Final disaasa or condition resulting in death) a.	Congestive Heart Failure	one day
Due to (or as a consequence of): b.	coronary artery disease	one year.
Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last. Due to (or as a consequance of): c.		
Due to (or as a consequance of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.: Cardiac arrhythmias, Renal Failure, Tracheal stenosis

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was casa referrad to medical examiner? 1☐ Yes 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Phyaician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the ceuse(s) and mennar stated.

29b. Signature and title of certifier: Sam Tellawi

29c. Licansa number: D34274

29d. Data signed (Month, Day, Year): 9-30-97

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Sam Tellawi, M.D. 7700 Old Branch Ave. #B102 Clinton, Md. 20735

State Registrar

31. Deta filad (Month, Day, Year): SEP 30 1997

32. Registrar's Signature: Julia Hudson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31072

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Horton

2. Data of Death Month/Day/Year: September 27, 1997

3. Time of Death: 8:30AM

4a. Facility Name *(If not institution, giva street and number)*: FAIRLAND NURSING CENTER

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 240-07-2998

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: Sept. 7, 1909

9. Birthpleca *(Steta or Foreign Country)*: Wake Co., N.C.

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☒Yas 2☐No

10e. Street and Number: 4303 Delmar Avenue

10f. Zip Code: 20748

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yas, Giva Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Taxi-Cab Driver

16b. Kind of Business/Industry: Self Employed

17. Father's Name *(First, Middla, Last)*: Hollis Horton

18. Mothar's Name *(First, Middle, Meiden Sumame)*: Minnie Robertson

19a. Informant's Name/Reletionship *(Type, Print)*: Lewis N. Horton - Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4303 Delmar Avenue, Temple Hills, MD 20748

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: Ft. Lincoln Cemetery

Deta: 10/2/97

20c. Location - City or Town, Stata: Brentwood, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Nama and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Ceusa (Final disease or condition resulting in death): a. PNEUMONIA — DAYS

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last:

b. Due to (or es e consequance of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Wes an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☑Nursing Homa 5☐Residance 6☐Othar *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accidant 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☑**Certifying Phyaician:** To tha best of my knowledge, death occurred et the tima, data and place, and due to the ceuse(s) end menner es stated. 2☐**Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and dua to tha cause(s) and manner statad.

29b. Signetura and title of certifiar

29c. Licansa number: D24997

29d. Date signed *(Month, Dey, Year)*: 9/29/97

30. Name end eddress of person who completed cause of daath (Item 23a) (Type, Print): LUIS A. CASAS MD 8317 CHERRY LANE LAUREL MD 20707

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 01 1997

32. Registrar's Signeture: Julia Strickson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31073

Amended # 1. & 29d. Per Doc. P.G.C. 10-1-97cf

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John F. B. Haugh Sr.
2. Date of Death (Month, Day, Year): Sept. 20 1997
3. Time of Death: 11:30 P.M.
4a. Facility Name (If not institution, give street and number): 3904 Norwalk Place
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215 52 6757
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 28, 1948
9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3904 Norwalk Place
10f. Zip Code: 20716
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Loan Officer
16b. Kind of Business/Industry: Union Trust Bank

17. Father's Name (First, Middle, Last): Robert Haugh
18. Mother's Name (First, Middle, Maiden Surname): Thelma Northrop

19a. Informant's Name/Relationship (Type, Print): Patricia Kay Haugh Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3904 Norwalk Place Bowie Maryland 20716

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery — Date: Sept. 24, 1997
20c. Location - City or Town, State: Brentwood Maryland

21. Signature of Funeral Service Licensee: ▶ Michael L Bigler
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. arrhythmia — immediate

Due to (or as a consequence of):
b. Congenital heart defect — 5 years

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
diabetes with complications of neuropathy, respiratory tract infection, hypertension, migraine headaches, gastroenteritis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] Attending
29c. License number: D34018
29d. Date signed (Month, Day, Year): ~~September~~ 22 1997 September

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 14201 Laurel Park Drive Ste 214 Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CR

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31074

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Lee Horton

2. Date of Death Month Day Yeer: September 29, 1997

3. Time of Death: 3:15 pm

4e. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-18-1235

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26, 1914

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10e. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 35 Milkshake Lane

10f. Zip Code: 21403

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedenl of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Roland E. Lee

18. Mother's Neme *(First, Middle, Maiden Surname)*: Nora A. Nothey

19a. Informant's Name/Relationship *(Type, Print)*: Howard Lee Horton - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4 Wainwright Avenue, Annapolis, Maryland 21403

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other piece)*: Fort Lincoln Cemetery

Date: 10/01/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: W. B. Gresh

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

CR

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth)

a. Peritonitis — 4 Days

Due to (or as e consequenca of):

b. Perforated Colon

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

CAD

Rheumatoid Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29e. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end placa, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: David E. Matteson

29c. License number: D35235

29d. Date signed *(Month, Day, Year)*: September 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David E. Matteson, M.D. 107 Ridgely Avenue, Annapolis, Maryland

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State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Henderson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31075

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Joseph Hepburn

2. Date of Death Month Day Year: September 25, 1997

3. Time of Death: 4:15PM

4a. Facility Name *(If not institution, give street and number)*: 3312 Randolph Road

4b. City, Town, or Location of Death: Wheaton

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-12-1356

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 10, 1919

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 3312 Randolph Road

10f. Zip Code: 20902

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaar or Dates: World War II

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Equipment Specialist

16b. Kind of Business/Industry: Navy Department

17. Father's Name *(First, Middle, Last)*: Charles Allen Hepburn

18. Mother's Name *(First, Middle, Maiden Surname)*: Ethel June Hendricks

19a. Informant's Name/Relationship *(Type, Print)*: Carol Hepburn-Campbell/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3312 Randolph Road, Wheaton, Maryland 20902

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park

Date: Sept. 29, 1997

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: David E. Perry M00803

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximata Interval Between Onsat and Death

Immediate Cause (Final disaase or condition resulting in daath)
a. Stroke — 3 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in daath) Last
b. Cerebral Arteriosclerosis — 10 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the causs of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☒No

25. Was cesa rafarred to medical examinar? 1☐Yas 2☒No

28. Placa of Death *(Check only one)*: Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Rasidence 6☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding investigation 6☐Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifiar *(Check only one)*: 1☒Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated. 2☐Medical Examiner: On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul T. Noone MD

29c. Licensa number: D07471

29d. Date signed *(Month, Day, Year)*: September 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul T. Noone, M.D. 50 West Edmonston Drive, #207, Rockville, Maryland 20852

State Registrar

31. Data filad *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31076

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES W. HAWKINS

2. Date of Death Month / Day / Year: Sept. 25, 1997

3. Time of Death: 3:55 P

4a. Facility Name *(If not institution, give street and number)*: Golden Oaks Nursing Home

4b. City, Town, or Location of Death: Laurel

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 220-01-0468

6. Sex: [X] 1 M [ ] 2 F

7. Age *(In yrs. last birthday)*: 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June26, 1921

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Geo.

10c. City, Town or Location: Springdale

10d. Inside City Limits: [X] 1 Yes [ ] 2 No

10e. Street and Number: 3800 Endicott Place

10f. Zip Code: 20774

10g. Citizen of What Country?: U.S.A.

11. Marital Status: [X] 1 Never Married [ ] 2 Married [ ] 3 Widowed [ ] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No. If Yes, Give Year or Dates: 43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): [ ] 1 Yes [X] 2 No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Robert Hawkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Dora E. Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Gerladine Easton (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3800 Endicott Pl., Springdale, MD 20774

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md Veterans Cem.

Date: 10/3/97

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: Dana K. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Brad

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CARCINOMA LUNG — Due to (or as a consequence of): — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CARCINOMA PROSTATE

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [X] 3 Probably [ ] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [ ] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No

26. Place of Death *(Check only one)*: Hospital: [ ] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA — Other: [X] 4 Nursing Home [ ] 5 Residence [ ] 6 Other *(Specify)*

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending Investigation [ ] 6 Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? [ ] 1 Yes [ ] 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D24997

29d. Date signed *(Month, Day, Year)*: 9/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUIS A CASAS 8317 CHERRY LANE LAUREL MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31077

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vivianne Jordan Harmon

2. Date of Death (Month, Day, Year): September 25, 1997

3. Time of Death: 5:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: 404 Bostwick Lane

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 208 34 4394

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 16,1944

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 404 Bostwick Lane

10f. Zip Code: 20878-1932

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): – ; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Resident Make-up Artist

16b. Kind of Business/Industry: Cosmetics

17. Father's Name *(First, Middle, Last)*: Lewis Jordan

18. Mother's Name *(First, Middle, Maiden Surname)*: Alethea Bugg

19a. Informant's Name/Relationship *(Type, Print)*: David Ervin Harmon/ Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 404 Bostwick Lane, Gaithersburg, MD 20878-1932

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. — Date: September 26, 1997

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] M00689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cervical Cancer — 11 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Pulmonary Metastases — 4 Months

Due to (or as a consequence of):
c. Bowel Obstruction — 1 Month

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 36670

29d. Date signed *(Month, Day, Year)*: September 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William L. Dahut, M.D. 9715 Medical Center Dr., Suite 230, Rockville, MD 20850

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31078

Reg. No.

Item #5 per FH, Film G-753 11-13-97 RC

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William L. Harding

2. Dete of Deeth — Month Dey Year: Sept. 27, 1997

3. Time of Deeth: 10:15 P.M.

4e. Fecility Neme (If not institution, give street end number): Suburban Hospital

4b. City, Town, or Location of Deeth: Bethesda

4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: ~~506-23-5557~~ 506-32-5557

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. lest birthday): 74 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): March 25,1923

9. Birthplece (Stete or Foreign Country): Omaha, NE

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 5404 Albia Road

10f. Zip Code: 20816

10g. Citizen of Whet Country?: U.S.A.

11. Merital Stetus: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Yeer or Deles: WWII

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 5+ College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Attorney

16b. Kind of Business/Industry: F.E.M.A. Legal Counsel Division

17. Fether's Neme (First, Middle, Lest): Jesse MacMillan Harding

18. Mother's Name (First, Middle, Maiden Surneme): Agnes Burkley

19a. Informent's Neme/Reletionship (Type, Print): Nancy Walsh Harding Wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5404 Albia Road, Bethesda, MD 20816

20e. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mount Comfort Crematory

Dete: 10/4/97

20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signeture of Funeral Service Licensee: Jeffry A. Pin

22. Neme end Address of Fecility: Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. Washington, D.C. 20016

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approxtmete Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth): e. Cardio Pulmonary Failure

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest:

b. Cardiac Arrhythmia

Due to (or es e consequence of):

c. Chronic Atrial Fibrillation

Due to (or es e consequence of):

d.

Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Piece of Deeth (Check only one): Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☒ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, and due to the ceuse(s) and manner es steted. 2 ☐ **Medical Examiner:** On the basis of exemineticn and/or Investigetion, in my opinion, deeth occurred et the time, date and piece, end due to the cause(s) end manner stated.

29b. Signeture and title of certifier: R C Daddario M.D.

29c. License number: D01110

29d. Dete signed (Month, Dey, Yeer): September 30, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Robert C. Daddario, M.D. 4030 Del Ray Avenue, Bethesda, MD 20814

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 01 1997

32. Registrar's Signeture: Jiuka Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

M.E. Dr. may

Brun

Harding Sept 27 1997 2305

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31079

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William David Hutchinson
2. Date of Death (Month, Day, Year): September 30, 1997
3. Time of Death: 6:30 AM
4a. Facility Name *(If not institution, give street and number)*: 18138 Bilney Drive
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-26-7630
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 5, 1922
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10e. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3614 Pear Tree Court
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technical Writer
16b. Kind of Business/Industry: United States Government

17. Father's Name *(First, Middle, Last)*: Robert Hutchinson
18. Mother's Name *(First, Middle, Maiden Surname)*: Marguerite Saunders

19a. Informant's Name/Relationship *(Type, Print)*: William D. Hutchinson/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17112 Flatwood Drive, Rockville, Maryland 20855

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: October 1, 1997
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Barbara J. McMullen Lawrence M00831
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Stroke — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Insulin Dependent Diabetes; Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* XX Daughter's Residence

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christy Lynd MD
29c. License number: D31839
29d. Date signed *(Month, Day, Year)*: September 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher C. Dunford, M.D., 615 W. Montgomery Avenue, Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31080

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARDELLE IRVING HUMPHREY

2. Date of Death (Month, Day, Year): SEPTEMBER 28, 1997

3. Time of Death: 12:50 Am

4a. Facility Name (If not institution, give street and number): WILSON HEALTH CARE CENTER

4b. City, Town, or Location of Death: GAITHERSBURG

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-16-3792

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 98 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 31, 1899

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Damascus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 26810 Grace Court

10f. Zip Code: 20872

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1917 1919

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Thomas Craven Humphrey

18. Mother's Name (First, Middle, Maiden Surname): Ada Isabelle Bower

19a. Informant's Name/Relationship (Type, Print): Barbara Beard (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26810 Grace Court, Damascus, MD 20872

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan CRematory | Date: 9/29/97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877

JW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral Arteriosclerosis — 5years

Due to (or as a consequence of):
b. —

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. —

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 07231

29d. Date signed (Month, Day, Year): SEPTEMBER 29, 1997

30. Name and address of ~~person who completed~~ cause of death (Item 23a) (Type, Print): JAMES R. MOORE, JR., M.D., 207 BROOKES AVENUE, GAITHERSBURG, MD 20877-2901

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997

32. Registrar's Signature: Tia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JONELL IRBY

2. Date of Death: Month Sept Day 29 Year 1997

3. Time of Death: 12 30 pm

4a. Facility Name (If not institution, give street and number): Circle Manor Nursing Center

4b. City, Town, or Location of Death: Kensington

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-54-8396

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 29, 1914

9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6306 Hardwood Drive

10f. Zip Code: 20706

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed)

Elementery/Secondery (0-12): 5th

College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Neme (First, Middle, Last): John Pitts

18. Mother's Neme (First, Middle, Meiden Surneme): Lillie ?

19a. Informent's Neme/Relationship (Type, Print): Melvin Irby (Son)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6306 Hardwood Dr., Lanham, MD 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Washington Nat'l Cem.

Dete: 10/10/97

20c. Location - City or Town, Stete: Suitland, MD

21. Signature of Funeral Service Licensee: Evan R. Snowden

22. Neme end Address of Feciility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in death)

a. Atherosclerotic coronary vascular disease years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as steted. 2☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end manner steted.

29b. Signature and Title of certifier:

29c. License number: D 34032

29d. Date signed (Month, Day, Year): 9/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JEANNE P. ASNER, 3720 FARRAGUT AVE KENSINGTON, MD 20895

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31082

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lucille H Jones

2. Date of Death Month Day Yaar: September 26 1997

3. Time of Death: 2:00 AM

4a. Facility Name *(If not institution, giva street and number)*: Doctors' Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 237 22 4633

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb. 29, 1912

9. Birthplaca *(State or Foraign Country)*: Virginia

Usual Rasidance of Decedant

10a. Stata: North Carolina

10b. County: Durham

10c. City, Town or Location: Durham

10d. Insida City Limits: ☒ Yas 2☐ No

10e. Street and Number: 114 Hilton Ave.

10f. Zip Coda: 27707

10g. Citizan of What Countiy?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada compiatad)*: Elementary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Earl VanDorn Hoffler

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Mary Pearl Jones

19a. Informant's Name/Ralationship *(Type, Print)*: Barbara J. Mills Daughter

19b. Mailing Addrass *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda)*: 502 Linden Place Danville Virginia 24541

20a. Mathod of Disposition: ☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, crematory or othar place)*: Maplewood Cemetery

Data: Sept. 29, 1997

20c. Location - City or Town, Stata: Durham N.C.

21. Signature of Funeral Service Licensee: Michael L Bizlan

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediate Causa (Final disaasa or condition rasulting in death): a. Multiple Myeloma

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last:

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to tha cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Chack only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowladga, daath occurrad at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, death occurrad at the tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and titla of cartifiar: Marvin D. Wells

29c. Licansa number: D2374

29d. Data signed *(Month, Day, Year)*: 9-26-97

30. Name and address of parson who completed causa of daath (Item 23a) (Type, Print): MARTIN D. WELTZ 7525 Greenway Ct Dr Greenbelt MD 20770

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 01 1997

32. Registrar's Signature: Jaba Atkinson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

LUCILLE HOFFLER JONES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #10A P.C.J.C 10/2/97

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31083

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSINA P. JACKSON

2. Date of Death (Month, Day, Year): SEPTEMBER 28, 1997

3. Time of Death: 08:50 PM

4a. Facility Name (If not institution, give street and number): DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death: LANHAN

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 227-40-7685

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 11, 1929

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD VA

10b. County:

10c. City, Town or Location: PETERSBURG

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 128 S. SYCAMORE STREET

10f. Zip Code: 23803

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 4TH

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CAFETERIA WORKER

16b. Kind of Business/Industry: SCHOOLS - PETERSBURG

17. Father's Name (First, Middle, Last): JOHN WALTER PIERCY

18. Mother's Name (First, Middle, Maiden Surname): ROSA JANE BOOKER

19a. Informant's Name/Relationship (Type, Print): EVELYN CASEY - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1026 ENOCH DR #5 COLUMBUS, GA 31906

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DINWIDDIE MEMORIAL PARK

Date: 10/4/97

20c. Location - City or Town, State: DINWIDDIE, VA

21. Signature of Funeral Service Licensee: by Walt-Pitt

22. Name and Address of Facility: BIANCHI FUNERAL SERVICE / BIANCO F. ST. 3718 22ND ST NE WASH, DC 20018

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MDME

29c. License number: D33954

29d. Date signed (Month, Day, Year): SEPTEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: Julia Stephenson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #26-4, 10/8/97, BMW, Montg.Co.perM.D.

Certificate of Death

Reg. No. 97 31084

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Charles	R	Janes	Sept. 28, 1997	2:20 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Carriage Hill Bethesda	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
396-07-4591	1☒ M 2☐ F	91 Yrs.			Aug. 16, 1906	St. Mary's OH

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5627 Knollwood Road	20816	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	3+	Accountant	Accounting

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Henry Clark Janes	Vera Gilbert

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mabel Janes Wife	5627 Knollwood Road, Bethesda, MD 20816

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arlington National Cem.	10/8/97	Arlington, Virginia

21. Signature of Funeral Service Licensee: Jeff B. Ross

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. Washington, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrest	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Coronary Artery Disease	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
George Graves MD	D 29353	September 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. George Graves 5530 Wisconsin Avenue, #925, Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 01 1997	Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31085

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pauline Marie Jones

2. Data of Death Month Day Year: September 27,1997

3. Time of Death: 12:17 A.M.

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 226-07-7033

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 1, 1918

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12517 Bushy Drive

10f. Zip Code: 20906

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Executive Secretary

16b. Kind of Business/Industry: N.I.H.

17. Father's Name *(First, Middle, Last)*: Henry Wyatt Parrish

18. Mother's Name *(First, Middle, Maiden Surname)*: Lona Ashworth

19a. Informant's Name/Relationship *(Type, Print)*: Brenda D. Miller/Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4226 Pennsboro Court, Chantilly, Virginia 20151

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park | Date: Sept.30,1997

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Michelle D. Kutta M00348

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. MASSIVE HEART ATTACK

Due to (or as a consequence of):
b. CORONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rafael A. Mathews, MD

29c. License number: D-18924

29d. Date signed *(Month, Day, Year)*: SEPTEMBER TWENTY-SEVEN NINETY SEVEN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAFAEL A. MATHEWS, MD 13018 GEORGIA AVE. WHEATON, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Ramsell

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31086

Amended # 1. Per Doc. P.G.C. 10-1-97 cr **Certificate of Death** Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): EDNA HATTIE KREITZER
2. Dete of Death Month Dey Yeer: SEPTEMBER 19 1997
3. Time of Death: 9:13PM
4e. Facility Neme (If not institution, give street end number): Prince George's Hospital
4b. City, Town, or Location of Deeth: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220 32 6820
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 72 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Jan. 26, 1925
9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street end Number: 8700 Maple Ave.
10f. Zip Code: 20720
10g. Citizen of What Country?: United States
11. Merital Status: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes ☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondery (0-12): 7 | College (1-4or 5+):
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Neme (First, Middle, Last): Eugene Bowen
18. Mother's Neme (First, Middle, Maiden Surneme): Hattie Wood
19e. Inlorment's Neme/Reletionship (Type, Print): Chester Kreitzer Jr. Son
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 12303 Cliffe Place Bowie Maryland 20715
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Maryland Veterans Cemetery Dete: Sept. 25, 1997
20c. Locetion - City or Town, Stete: Cheltenham Maryland
21. Signeture of Funerel Service Licensee: James L Downs
22. Neme end Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death): e. Multisystem failure
Due to (or as e consequence of):
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest:
b. small intestine necrosis & perforation
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: diverticulosis with colovaginal fistula steroid dependence

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Yeer): None
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner steted.
29b. Signeture end title of certifier: Bertram Weisbaum MD
29c. License number: D 10311
29d. Dete signed (Month, Day, Year): 9/26/97
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Bertram Weisbaum MD 7500 Hanover Parkway Greenbelt Md. 20770

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(10)

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 01 1997
32. Registrar's Signeture: Debbie Matheson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31087

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Mary Jane Kidwell

2. Dete of Deeth Month / Dey / Yeer: September 23, 1997

3. Time of Deeth: 6:30 PM

4e. Feciility Neme *(If not institution, give street end number)*: Fox Chase Nursing Home

4b. City, Town, or Location of Deeth: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-10-9053

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Dec. 2, 1916

9. Birthplece *(Stete or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 2015 East West Highway

10f. Zip Code: 20910

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk

16b. Kind of Business/Industry: Private

17. Fether's Neme *(First, Middle, Last)*: William Henry Brock

18. Mother's Name *(First, Middle, Meiden Surname)*: Nannie Lee Newton

19e. Informant's Name/Reletionship *(Type, Print)*: William R. Brock-Nephew

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 11550 Stewart Lane (#213) Silver Spring, Maryland 20904

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Fort Lincoln Cemetery

Dete: 9-26-97

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signeture of Funerel Service Licensee: Lisa S. Johnson

22. Neme end Address of Feciility: Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, Maryland 20722

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one causa on eech line.

Approximete Intarval Between Onset end Deeth

Immedlete Ceusa (Finel diseese or condition resulting in deeth) e. BREAST CANCER — 9 MONTHS

Dua to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that Initieted avants resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:

29c. License number: D01120

29d. Dete signed *(Month, Dey, Yeer)*: SEPTEMBER 30, 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): WALTER E. GOOZH, M.D., 1299 LAMBERTON DRIVE, WHEATON, MARYLAND 20902

State Registrar

31. Deta filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signetura

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

DHMH 16 Rev 6/95

97 31088

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eugenia Kviesitis				2. DATE OF DEATH (Month, Day, Year): September 29, 1997	3. TIME OF DEATH: 6:00 P M
4. SOCIAL SECURITY NUMBER: 109-26-0427	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 98 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 27, 1899	8. BIRTHPLACE (State or Foreign Country): Russia
9a. FACILITY NAME (If not institution, give street and number): Sacred Heart Home			9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5805 Queens Chapel Road		10f. ZIP CODE: 20782	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Translator	16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): Peter Kviesitis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Shatalov	
19a. INFORMANT'S NAME (Type/Print): Maria Potapov / POA		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7424 Piney Branch Road, Takoma Park, Maryland 20912	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Rock Creek Cemetery	DATE: 10/1/97	20c. LOCATION — City or Town, State: Washington, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Alan J. Donnell		22. NAME AND ADDRESS OF FACILITY: Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	72HRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PROGRESSIVE CEREBRAL THROMBOSIS	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. HYPERTENSIVE CARDIOVASCULAR DISEASE	YEARS.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Marta Anne Schneider MD	29c. LICENSE NUMBER: D26331	29d. DATE SIGNED (Month, Day, Year): ▶ 9/29/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTA ANNE SCHNEIDER MD 5401 MACARTH. BLVD NW WASH DC 20016		
31. DATE FILED (Month, Day, Year): OCT 02 1997	32. REGISTRAR'S SIGNATURE: Erika Davidson-Randall	

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31089

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Lest)*: HORTENSE KEMPER

2. Dete of Deeth: Month Sept. Dey 26 Yeer 1997

3. Time of Death: 5:00A.M.

4e. Fecility Neme *(If not institution, give street end number)*: Larkin Chase Nursing Facility

4b. City, Town, or Location of Deeth: Bowie

4c. County of Deeth: Prince George's

Funeral Director

5. Sociel Security Number: 578 40 1957

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 67 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Mar. 5,1930

9. Birthplece *(Stete or Foreign Country)*: Washington, D.C.

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 801 Carry Pl.

10f. Zip Code: 20774

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - Americen Indien, Bleck, Whita, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Librarian

16b. Kind of Business/Industry: U.S. Government

17. Fethar's Name *(First, Middla, Lest)*: Colbert Holmes Sr.

18. Mothar's Neme *(First, Middle, Maiden Surneme)*: Helen Frenzley

19e. Interment's Name/Reletionship *(Type, Print)*: Carole Holmes (Sister)

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 801 Carry Pl.,Upper Marlboro, Maryland 20774

20e. Mathod of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cramatory or other piece)*: Ft. Lincoln Cemetery — Deta: 10/1/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signeture of Funeral Service Licensee: Steven E. Smith

22. Neme end Address of Fecility: McGuire Funeral Service Inc. 7400 Georgia Ave.,N.W.,Washington,D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the diseesa, or complications thet causad the death. Do not entar the mode of dying, such es cardiac or respiretory errest, shock, or heert feilura. List only one ceusa on eech line.

Approximete Interval Betwaen Onset end Death

Immediate Cause *(Final disease or condition resulting in death)*

a. CARDIAC ARRHYTHMIA — < 30 mins

Due to (or as a consequence of):

b. CARDIOMYOPATHY.

Sequentially list conditions, if eny, leading to immedieta ceuse. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c. RENAL FAILURE.

Due to (or es e consequence of):

d.

Part II. **Other eignificent conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

PVD.

23b. **Did tobecco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Wara autopsy tindings evelleble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes cese referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☒Nursing Home 5☐Residance 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To tha bast of my knowledge, daath occurred at tha time, date and place, and due to tha causa(s) and manner as stated. 2☐**Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D-14525

29d. Date signed *(Month, Day, Year)*: 09-26-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): S.J.RAO,MD-4000-Mitchellville Road,#220,Bowie-MD-20716.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

Amend #4, 10/2/97, BMW, Montg. Co.

97 31090

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARTHA KAHN
2. DATE OF DEATH (Month, Day, Year): Sept. 22, 1997
3. TIME OF DEATH: 7:00 p M
4. SOCIAL SECURITY NUMBER: 109-14-5516 / 050-18-6842
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 11, 1916
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Rockville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6121 Montrose Rd.
10f. ZIP CODE: 20852
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+): 1
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Jacob Agatstein
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Greenberg
19a. INFORMANT'S NAME (Type/Print): Rosalind Houseknecht
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12116 Hunters Lane Rockville, MD 20852
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Moses Cemetery — DATE: 9/24/97
20c. LOCATION — City or Town, State: Long Island, N.Y.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ASPIRATION PNEUMONIA, BOTH LOWER LOBES	1 WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	MULTI-INFARCT DEMENTIA	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Attending Physician
29c. LICENSE NUMBER: D18084
29d. DATE SIGNED (Month, Day, Year): ▶ SEPTEMBER 23, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D.D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852

31. DATE FILED (Month, Day, Year): SEP 24 1997
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #20b, 9/29/97, EMW, Montg.Co.

Certificate of Death

Reg. No. 97 31091

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Henry Kirkwood

2. Data of Death (Month, Day, Year): September 26, 1997

3. Time of Death: 11:00 AM

4a. Facility Name (If not institution, give street and number): 906 Beacon Square Court, #115

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 418-10-1322

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jan. 19, 1917

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 906 Beacon Square Court #115

10f. Zip Code: 20878

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management Analyst

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Joseph Henry Kirkwood

18. Mother's Name (First, Middle, Maiden Surname): Jenny Radford

19a. Informant's Name/Relationship (Type, Print): Jo Helen Kirkwood/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 906 Beacon Square Ct.#115, Gaithersburg, MD 20878

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Forest Hill Cemetery

Date: ~~Sept. 1, 1997~~ 10/1/97

20c. Location - City or Town, State: Birmingham, Alabama

21. Signature of Funeral Service Licensee: Ronald Faust M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel A. Reiskin, M.D.

29c. License number: D09764

29d. Date signed (Month, Day, Year): September 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joel A. Reiskin, M.D. 15215 Shady Grove Road, #303, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Henry Ludwig

2. Date of Death Month/Day/Year: SEPTEMBER 28 1997

3. Time of Death: 7:30 PM

4a. Facility Name (If not institution, give street and number): 3060 Crown Circle

4b. City, Town, or Location of Death: Manchester

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 216-16-9317

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8/27/08

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Finksburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2921 Cedarhurst Road

10f. Zip Code: 21048

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): gardener & chauffeur

16b. Kind of Business/Industry: private home

17. Father's Name (First, Middle, Last): Clarence Howard Ludwig

18. Mother's Name (First, Middle, Maiden Surname): Jenny M.

19a. Informant's Name/Relationship (Type, Print): Elizabeth Barnes, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1973 Deer Park Rd., Finksburg, MD 21048

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Gardens | Date: 10/1/97

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: ▶ Katherine Pritts - Sweitzer

22. Name and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. COPD — 1990

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CORONARY HEART DISEASE; CHF; CA PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D18099

29d. Date signed (Month, Day, Year): 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] P.O. Box 391 Westminster, Md.

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TREVA M. LEPPO

2. Date of Death (Month, Day, Year): SEPTEMBER 24 1997

3. Time of Death: 6:10PM

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 173-38-8591

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC 20, 1911

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: PENNSYLVANIA

10b. County: YORK

10c. City, Town or Location: HANOVER

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2560 BALTIMORE PIKE

10f. Zip Code: 17331

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): WILLIAM ANDREW STERNER

18. Mother's Name (First, Middle, Maiden Surneme): IRENE SARA BAUM

19a. Informant's Name/Relationship (Type, Print): WENDELL LEPPO, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 741 SATELLITE DR, YORK, PA 17403

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): ST. DAVID'S SHERMAN

Date: 9/27

20c. Location - City or Town, State: HANOVER, PA

21. Signature of Funeral Service Licensee: ▶ Steven W. Eline

22. Name and Address of Facility: ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. OVARIAN CANCER — 5 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medicei examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medicel Examinar**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: ▶ Nicholas C. Lambrou MD

29c. License number: RES-000

29d. Date signed (Month, Dey, Year): SEPTEMBER 24 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): NICHOLAS C. LAMBROU 600 N. WOLFE STREET BALTIMORE, MARYLAND 21287

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: ▶ Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31094

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys May Lewis
2. Data of Death (Month, Day, Year): September 28, 1997
3. Time of Death: 8:50PM
4a. Facility Name (If not institution, give street and number): Doctors' Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 159 14 9671
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 11, 1914
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4020 William Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: County Schools

17. Father's Name (First, Middle, Last): Issac N. Sprowls
18. Mother's Name (First, Middle, Maiden Surname): Unavailable

19a. Informant's Name/Relationship (Type, Print): David Glenn Lewis Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1507 Beichler Rd. Garner North Carolina 27529

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory Date: Sept. 30, 1997
20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — minutes
Due to (or as a consequence of): Coronary atherosclerosis — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of): —
c. Due to (or as a consequence of): —
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: New Onset Seizure disorder, Hypertension, Duodenal ulcer back, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D24720
29d. Date signed (Month, Day, Year): 9-29-97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAVINDER K. RUSTAGI MD 6132 Landover Road, Cheverly Md 20785

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gladys May Lewis

or

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gertrude Hendrick Latvinsky
2. Deta of Death (Month, Day, Yeer): September 29, 1997
3. Tima of Death: 9:45 am
4a. Facility Name (If not institution, giva street and number): 8703 58th Avenue
4b. City, Town, or Location of Deeth: Berwyn Heights
4c. County of Death: Prince George's

Funeral Director

5. Social Security Numbar: 579-94-5426
6. Sax: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Nov. 2, 1914
9. Birthpleca (State or Foraign Country): Virginia

Usuel Residance of Decedant

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Berwyn Heights
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8703 58th Avenue
10f. Zip Code: 20740
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse
16b. Kind of Business/Industry: Medical Field

17. Father's Name (First, Middle, Last): Frank L. Hendrick
18. Mothar's Nama (First, Middle, Meiden Surneme): Carrie Belle Langston

19a. Informant's Name/Relationship (Type, Print): Julius Latvinsky - Spouse
19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code): 8703 58th Avenue, Berwyn Heights, Maryland 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Crestview Memorial Park
Date: 10/01/97
20c. Location - City or Town, State: South Hill, Virginia

21. Signature of Funeral Service Licensee: Kathy Jean Dent
22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each ane.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in deeth): e. Cerebral Vascular accident

Due to (or as e consequence of):

Sequantially list conditions, if eny, leading to immediata causa. Enter Underlying Ceuse (Disaase or Injury that initiated events rasulting in death) Last:
b.
Due to (or es e consequance of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

29a. Cartifiar (Check only one): 1☒ **Certifying Phyalcian:** To the best of my knowledga, daeth occurrad at tha time, date and piece, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, daeth occurred at tha time, data end place, and due to tha causa(s) and manner stated.

29b. Signature end title of certifier: A. O. Mostaghan
29c. Licensa number: D46093
29d. Date signed (Month, Dey, Year): Sept 29, 1997

30. Name end eddress of person who complated causa of death (Item 23e) (Type, Print): A. O. Mostaghan 7305 Hanover Parkway, Suite A, Greenbelt, Maryland 20770

State Registrar

31. Data filed (Month, Dey, Year): OCT 01 1997
32. Registrer's Signetura: Julie Anderson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31096

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Yaar	3. Tima of Death
INEZ	DARBY	LEVERE	SEPT. 17, 1997	8:00 p.m.

4a. Facility Nama (If not institution, giva street and number)	4b. City, Town, or Location of Daath	4c. County of Death
PRINCE GEORGE'S HOSPITAL AND MEDICAL CENTER	CHEVERLY	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Undar 1 Yaar: Months / Days	If Undar 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (State or Foraign Country)
225-20-9274	1☐ M 2☒ F	75 Yrs.			JAN. 11, 1922	VIRGINIA

To Be Completed by Funeral Director

Usual Rasidanca of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
MARYLAND	PRINCE GEORGES	CLINTON	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizan of Whet Country?
9404 MILLER COURT	20735	U S A

11. Marital Status	12. Was Decedant Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.)	14. Raca - Amarican Indian, Black, White, atc.
1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: AFRO AMERICAN

15. Dacedant's Education (Spacify only highast grada completed)		16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	1	PRODUCTION WORKER	MANUFACTURING

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maiden Sumama)
JOHN ELLIOTT CORBIN	MARY ALICE WOOD

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)
VERA BLAKE	904 MILLER COURT CLINTON, MD 20735

20a. Mathod of Disposition	20b. Place of Disposition (Nama of camatary, cramatory or othar place)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	EBENEZER BAPTIST CHURCH	9/23/97	TIDEWATER

21. Signature of Funaral Sarvice Licansee	22. Nama and Addrass of Facility
▶ Berry O. Waddy	BERRY O. WADDY P.O.BOX 305 LANCASTER, VA 22503

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only ona ceusa on aach lina.

		Approximate Interval Between Onset and Death
Immediata Causa (Final disaasa or condition rasulting in death)	a. Pneumonia	
	Dua to (or as a consequance of):	
Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Diseasa or injury that initiated avants rasulting in daath) Last	b.	
	Dua to (or as a consequence of):	
	c.	
	Dua to (or as a consaquanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Cerebrovascular Disease - Congestive Heart Failure

Coronary Artery Disease - Diabetes Mellitus

Hypertension, Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy pertormad?	24b. Ware autopsy findings availeble prior to complation of causa of deeth?
1☐ Yas 2☒ No	1☐ Yes 2☐ No

25. Was casa referred to madical examinar?	28. Place of Deth (Check only ona)	
1☐ Yas 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify)

27. Mennar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)			28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and placa, and dua to the ceuse(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of cartifiar	29c. Licansa number	29d. Data signed (Month, Day, Yaar)
▶ George C. Hajjar, Jr.	D39550	9/18/97

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)
George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706

State Registrar

31. Data filad (Month, Day, Yaar)	32. Registrar's Signatura
OCT 10 1997	Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31097

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LISLE THORNTON LIPSCOMB, SR.
2. Date of Death Month / Day / Year: SEPTEMBER 27 1997
3. Time of Death: 2350
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-01-0981
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 19, 1917
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9410 Gentle Circle
10f. Zip Code: 20879
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942 - 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Self Employed
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Adgate A. Lipscomb
18. Mother's Name *(First, Middle, Maiden Surname)*: May Thornton

19a. Informant's Name/Relationship *(Type, Print)*: June L. Thompson (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10237 Ridgeline Drive, Gaithersburg, MD 20879

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 9/29/97
20c. Location - City or Town, State: Alexandira, Virginia

21. Signature of Funeral Service Licensee: Gary M. [illegible]
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersubrg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	PNEUMONIA	5 DAYS
Due to (or as a consequence of): b.	CEREBRAL VASCULAR ACCIDENT	7 DAYS
Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

GASTROINTESTINAL BLEEDING
CARDIOMYOPATHY
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Straat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ralph M. Coan
29c. License number: D0 11 91
29d. Data signed *(Month, Day, Year)*: SEPTEMBER 28 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RALPH M. COAN M.D. 4400 EAST WEST HIGHWAY, BETHESDA MARYLAND 20814

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 30 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31098

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jerold Linder

2. Date of Death Month Day Year: Sep. 28, 1997

3. Time of Death: 7:45PM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-74-5718

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 24, 1925

9. Birthplace *(State or Foreign Country)*: NY

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8918 First Ave.

10f. Zip Code: 20910

10g. Citizen of What Country?: US

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Abraham Linder

18. Mother's Name *(First, Middle, Maiden Surname)*: Gussie Steingart

19a. Informant's Name/Relationship *(Type, Print)*: Ruth Eisenstadt/Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8918 First Ave. Silver Spring, Md. 20910

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Memorial Gardens

Date: 10/1/97

20c. Location - City or Town, State: Falls Church, Va.

21. Signature of Funeral Service Licensee: Edward Sagel

22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Presumed cardiac arrest — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

1) Coronary artery dz

2) CHF

3) Type II DM

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Z D

29c. License number: BM34059 36

29d. Date signed *(Month, Day, Year)*: 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THERESA A McCAUGHEY 9700 Georgia Ave Silver Spring Md

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

4 (4)

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Amended item # 28f per physician
10/9/97 Carroll Co. p.l.c.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31099
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CURTIS MORSBERGER
2. Date of Death Month Day Yeer: September 27 97
3. Time of Death: 1:10 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 213-52-1428
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 22 1948
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Carroll
10c. City, Town or Location: Finksburg
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 1716 Doe Drive
10f. Zip Code: 21048
10g. Citizen of What Country?: United States

11. Merital Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - Americen Indien, Black, White, etc. Specify: white
15. Decedent's Edcetion (Specify only highest grade completed): Elementery/Secondery (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Patrolman First Class
16b. Kind of Business/Industry: Balt. County Police
17. Fether's Neme (First, Middle, Last): Christian Walter Morsberger
18. Mother's Neme (First, Middle, Malden Surname): Elizabeth Marie Williams
19a. Informent's Name/Reletionship (Type, Print): Anita Morsberger, wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1716 Doe Drive, Finksburg, MD 21048
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Meadow Branch Cemetery | Dete: 10/01/97
20c. Location - City or Town, State: Westminster, MD
21. Signature of Funeral Service Licensee: ▶ Katherine Pritts-Sweitzer
22. Neme end Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset end Death
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	96% TBSA Burns	15 hours
Due to (or es e consequence of):		
Sequentiellty list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest b.		
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: None

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicel exeminer? 1 [X] Yes 2 [ ] No

26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [ ] Neturel 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): Sept 26, 1997
28b. Time of Injury: 10 P M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how Injury occurred: Gasoline explosion
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): Gas Station
28f. Location (Street end Number or Rural Route Number, City, Town, or Locetion): ~~Lutherville~~ Linthicum, MD

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2 [ ] Medical Exeminer: On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end piece, end due to the ceuse(s) end manner steted.

29b. Signature and title of certifier: ▶ Lesley Wong MD
29c. License number: D35276
29d. Date signed (Month, Day, Year): Sept 27, 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): LESLEY WONG, Johns Hopkins Bayview Medical Center

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Lisa Thurber Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-5616-031
B.K.S
ANTONIO ESPARZA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31100

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antonio Esparza Martines
2. Date of Death (Month, Day, Year): SEPT. 30, 1997
3. Time of Death: 2035 PM
4a. Facility Name (If not institution, give street and number): SUBURBAN HOSPITAL
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 225-53-6893
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 10, 1945
9. Birthplace (State or Foreign Country): Mexico

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X
10e. Street and Number: 12230 Viers Mill, Rd
10f. Zip Code: 20906
10g. Citizen of What Country? Mexico

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No — X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☐ No — X — Specify: Mexican
14. Race - American Indian, Black, White, etc. Specify: Hispanic
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Bernie Mallom
17. Father's Name (First, Middle, Last): Pedro Esparza
18. Mother's Name (First, Middle, Meiden Surname): Comsuelo Martines
19a. Informant's Name/Relationship (Type, Print): Jesus Esparza
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12230 Viers Mill Rd, Silver Spring 20906
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State — X — 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Tepusco Jalisco
Date: 9-10-97
20c. Location - City or Town, State: MEXICO
21. Signature of Funeral Service Licensee: Terry Austin
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. NW.,WASH,DC. 20011

To Be Completed by Funeral Director

pamph: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the ceuse of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Wes case referred to medical examiner? ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Naturel 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer): 9-30-97
28b. Time of Injury: 1940 M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Struck by automobile
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify): Street
28f. Location (Street and Number or Rural Route Number, City or Town, State): Viers Mill Road Montgomery County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Myrtle H Macky, MD
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): OCT. 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Yeer): OCT 03 1997
32. Registrer's Signatura: Julia Strother-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen F. Murphy

2. Date of Death: Month OCTOBER, Dey 2, Year 1997

3. Time of Death: 1:00AM

4a. Facility Name (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: A CHARLES

Funeral Director

5. Social Security Number: 025-18-9736

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Deys | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): July 5, 1917

9. Birthplace (State or Foreign Country): Boston, Mass.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Brandywine

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 16103 Beechnut Dr.

10f. Zip Code: 20613

10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Proofreader

16b. Kind of Business/Industry: Telephone Co.

17. Father's Name (First, Middle, Last): Vincent Garro, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Frances DeBlasis

19a. Informant's Name/Ralationship (Type, Print): Pamela A. Wilson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item 10

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 10/4/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Geo P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Helen Murphy

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, oohaart failure. List only ona cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Cardiac Arrest

Sequentielly list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last

Due to (or as a consequence of):

c. Ca. of Breast

Due to (or es a consequence of):

d. DIC/ Thrombocytopenia/ Anemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and place, and due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and menner steted.

29b. Signatura and titla of cartifier: ▶ M. Hunasikatti MD

29c. License number: D45642

29d. Date signed (Month, Day, Year): 10/2/97

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print): Mahadevappa Hunasikatti, MD Cenna Medical Center, 7-C Post Office Road Waldorf, Maryland 20602

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State Registrar

31. Data filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Julia Strickon Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31102

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDNA MAXSON

2. Date of Death Month Day Year: September 25, 1997

3. Time of Death: 2:03AM

4a. Facility Name *(If not institution, give street and number)*: Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 219-22-5496

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 2, 1917

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1077 Largo Road, #216

10f. Zip Code: 20774

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Philo Marvin

18. Mother's Name *(First, Middle, Maiden Surname)*: Mytrle Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Bryant-Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 421 Marshall Manor, Silver Spring, MD 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olive Baptist Cemetery

Date: September 28, 1997

20c. Location - City or Town, State: Salem, West Virginia

21. Signature of Funeral Service Licensee: Richard Rendon

22. Name and Address of Facility: Greathouse Funeral Home, Route 1, Box 59, Salem, West Virginia

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia — 48 Years

Due to (or as a consequence of):
b. Aspiration — 48 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Dysphagia — 3 wks
Due to (or as a consequence of):
d. Sepsis — 48 hrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
lung Cancer
COPD
CAD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 034860

29d. Date signed *(Month, Day, Year)*: 9/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. OLEG SHPAK, 9470 ANNAPOLIS ROAD, SUITE 210, LANHAM, MD 20706

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 30 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

R MAXSON, Edna Florence

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31103

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lavenia McGinn

2. Date of Death (Month, Day, Year): Sept. 27 1997

3. Time of Death: 3:10 A.M.

4a. Facility Name (If not institution, give street and number): Hillhaven Nursing Center

4b. City, Town, or Location of Death: Adelphi

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 213 48 7943

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 28, 1903

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Crownsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 715 North Riverside Drive

10f. Zip Code: 21032

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Name (First, Middle, Last): Isaac B. Cleveland

18. Mother's Name (First, Middle, Maiden Surneme): Lavenia Lucas

19e. Informant's Name/Reletionship (Type, Print): Donald McGinn Son

19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6631 AuBurn Ave. New Carrollton Maryland 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery | Date: Sept. 30, 1997

20c. Location - City or Town, State: Brentwood Maryland

21. Signature of Funeral Service Licensee: ▶ Michael L Bialer

22. Name and Address of Fecility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure

(Due to (or as a consequence of):

b. atrial fibrillation — years

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension — years

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D25009

29d. Date signed (Month, Dey, Year): September 29, 1997

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Pamela Mulshine, MD 11251 Lockwood Dr. Silver Spring Md. 20901

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: ▶ John Charles Rudolf

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31104

Amended # 7. P.G.C. 10-1-97 cr

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Tyrone W Marshall

2. Dete of Deeth: Month 9 Day 25 Yeer 97

3. Time of Deeth: 10:20 A.

4e. Feclity Neme (If not Institution, give street and number): Heartland Health care center of Hyattsville

4b. City, Town, or Location of Deeth: Hyattsville

4c. County of Deeth: Prince George

Funeral Director

5. Sociel Security Number: 579-74-6843

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): ~~11-05-56~~ Yrs. 40 yrs old

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): 11-05-56

9. Birthplece (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: Md.

10b. County: P.G.

10c. City, Town or Location: Fairmount Hgts.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 702 59th Avenue

10f. Zip Code: 20743

10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12th / College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Selector

16b. Kind of Business/Industry: Safeway Food Store

17. Fether's Neme (First, Middle, Last): William Marshall

18. Mother's Neme (First, Middle, Meiden Surneme): Ruth Coleman

19e. Informent's Name/Reletionship (Type, Print): William Marshall/Father

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): Same as # 10 above

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Harmony Mem. Park

Dete: 10/1/97

20c. Location - City or Town, Stete: Landover, Md.

21. Signeture of Funerel Service Licensee: Gary W. Craft

22. Neme end Address of Feciility: H.S.Washington & Sons, Inc. 4925 Burroughs Ave., N.E.

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. CARDIO RESPIRATORY FAILURE

Due to (or es e consequenca of): AIDS

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of): SEPSIS

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: N/A

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify):

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end plece, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: MD

29c. License number: D42019

29d. Dete signed (Month, Dey, Yeer): SEPT 26TH 1997

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): IMRAN CHOWDHURY MD 7356 VAN DUSEN Rd LAUREL MD 20707

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 01 1997

32. Registrer's Signeture: Judy Warren-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31105

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anthony Paul Manzanares
2. Date of Death Month / Day / Year: September 27, 1997
3. Time of Death: 5:00 pm
4a. Facility Name *(If not institution, give street and number)*: 4808 55th Avenue
4b. City, Town, or Location of Death: Hyattsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 098-01-7547
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 24, 1898
9. Birthplace *(State or Foreign Country)*: Nicaragua

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4808 55th Avenue
10f. Zip Code: 20781
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printer
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Paul Manzanares
18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Samper

19a. Informant's Name/Relationship *(Type, Print)*: Louise Manzanares - Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4808 55th Avenue, Hyattsville, Maryland 20781

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery
Date: 10/01/97
20c. Location - City or Town, State: Silver Spring, MD.

21. Signature of Funeral Service Licensee: W B Gasch
22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Prostate Carcinoma — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Parkinsonism, Renal insufficiency.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W Q Quinn MD
29c. License number: D32261
29d. Date signed *(Month, Day, Year)*: 9-29-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Richard J. Feldman, MD 9300 Annapolis Rd, Lanham MD 20706

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(5)

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: Judi Davidson Reed II

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 18 PG, GC, 10/2/97 & 10e — *Certificate of Death* — Reg. No. 97 31106

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELFRIEDA MORGAN
2. Date of Death Month / Day / Year: SEPTEMBER 26, 1997
3. Time of Death: 5:57 AM
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 239-33-1244
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 31, 1937
9. Birthplace *(State or Foreign Country)*: LIBERIA

Usual Residanca of Dacedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 13626 JACQUELINE ~~DR.~~ Ct.
10f. Zip Code: 20904
10g. Citizen of Whet Country?: UNITED STATES AMERICA

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5 YRS.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DIPLOMAT/ATTORNEY
16b. Kind of Businass/Industry: PRIVATE

17. Fathar's Name *(First, Middla, Last)*: JOHN HENRY RICKS
18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH ~~AMMONDS~~ AMMOMDS

19a. Informant's Name/Relationship *(Type, Print)*: ELIZABETH BRISBANE (NIECE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3601 DUNSINANE DRIVE SILVER SPRING MD. 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: GATE OF HEAVEN — Data: OCT. 4, 1997
20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signeture of Funeral Servica Licensee: [signature]
22. Neme end Address of Fecility: JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C. 20011

Physician /Medical Examiner

23a. Enter the disease, or complications that caused the death. Do not entar tha moda of dying, such es cardiac or respiratory arrest, shock, or haart faiture. List only ona cause on each line.

		Approximate Interval Between Onset and Death
Immediata Causa (Finat disease or condition resulting in daath)	a. Sepsis	1-2 days
	Due to (or as a consequance of):	
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or Injury thet initiated events resulting in death) Last	b.	
	Due to (or as e consequenca of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Dilated Cardiomyopathy, Acute tubular necrosis, Acute pancreatitis, Metabolic acidosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Ware autopsy findings availabie prior to complation of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residanca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At homa, farm, street, factory, office buiiding, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the bast of my knowiedga, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Madical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and piaca, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier: Jeffrey A Perlmutter MD
29c. License number: D47188
29d. Date signed *(Month, Day, Year)*: September 29, 1997

30. Name and aodress of person who completed cause of death (Item 23a) (Type, Print): Jeffrey A. Perlmutter, M.D. 6240 Montrose Road Rockville MD 20852.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrar's Signature: John Thurman-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31107

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas C. Mason
2. Date of Death (Month, Day, Year): September 25, 1997
3. Time of Death: 8:45 AM
4e. Facility Name (If not institution, give street and number): Manor Care Silver Spring
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 219-42-3784
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 6, 1910
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14800 Birch Springs Court
10f. Zip Code: 20905
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: Unknown
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Forestry
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): Louis Mason
18. Mother's Name (First, Middle, Maiden Surname): Mary Lynn
19a. Informant's Name/Relationship (Type, Print): Marilyn M. Keiser (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14800 Birch Springs Court Silver Spring, MD 20905
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 9/29/97
20c. Location - City or Town, State: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: TRACY A. STUMP
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in death): e. Pulmonary Embolus — Minutes

Due fo (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due fo (or es e consequenca of):
d.

Part II. **Other signiticant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior fo completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted.

29b. Signature end title of certifier: Jenny Y Moy MD
29c. License number: D43260
29d. Date signed (Month, Day, Year): September 26, 1997

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Jenny Y Moy, MD 14333 Laurel Bowie Rd #307 Laurel MD 20708

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31108

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Marilyn Ann Marton

2. Date of Death Month Dey Yeer: September 20, 1997

3. Time of Death: 10:58 AM

4e. Facility Nama (If not institution, giva streat end number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-44-4659

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year Months Deys / If Under 24 Hrs. Hours Min.:

8. Dete of Birth (Month, Dey, Year): Dec. 9,1934

9. Birthplece (State or Foreign Country): Washington,D.C.

Usual Residance of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3307 Pendleton Drive

10f. Zip Coda: 20902

10g. Citizan of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Amarican Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elamantary/Secondery (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Social Worker

16b. Kind of Business/Industry: Associated Catholic Charities

17. Fethar's Name (First, Middle, Last): Paul Jones

18. Mother's Neme (First, Middle, Maiden Surnema): Louise Nalley

19e. Informent's Name/Reletionship (Type, Print): Albert W. Marton (husband)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda): 3307 Pendleton Drive Silver Spring,Maryland 20902

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, cremetory or other piece): Gate of Heaven Cemetery

Date: 9/24/97

20c. Location - City or Town, Stete: Silver Spring,Maryland

21. Signature of Funerel Service Licensee: ▶ Mark Pickel

22. Name end Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complicetions thet caused the deeth. Do not anter the mode of dying, such es cerdiec or raspiratory errest, shock, or heart failure. List only ona causa on eech line.

Approximata Intervel Between Onset end Death

Immediate Ceuse (Finel diseasa or condition resulting in death): e. Cor Pulmonale — Years

Dua to (or as a consequence of):

Saquentially list conditions, if any, laading to immediata cause. Enter Underlying Ceuse (Diseese or injury thet initieted evants resulting in daeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other efgnificant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Wara eutopsy findings evelleble prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yas 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred et the time, deta and place, and due to tha ceuse(s) and mannar as statad. 2☐ **Medical Examiner:** On the besis of axamination end/or investigetion, in my opinion, death occurred et the time, dete and piece, and due to tha cause(s) end mennar stated.

29b. Signeture end title of certifier: ▶ Elliot R. Goldstein

29c. License number: D0358 1

29d. Data signed (Month, Dey, Year): September 26,1997

30. Name and eddress of parson who completed ceuse of death (Item 23e) (Type, Print): Elliot R. Goldstein, M.D. 9410 Old Georgetown Road Bethesda,Maryland 20814

State Registrar

31. Dete filed (Month, Dey, Year): SEP 29 1997

32. Registrar's Signature: ▶ Sylvia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31109

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella Agnes Mankevich
2. Date of Death: Month 09 Day 26 Year 97
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 179-14-3665
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 16, 1921
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3300 Kayson Street
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator
16b. Kind of Business/Industry: Telephone

17. Father's Name (First, Middle, Last): Anthony Mankevich
18. Mother's Name (First, Middle, Maiden Surname): Anna Mary Mitrosz

19a. Informant's Name/Relationship (Type, Print): Eleanor M. Conover (sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3300 Kayson Street Wheaton, Maryland 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Saint Casimir Cemetery
Date: 10/2/97
20c. Location - City or Town, State: Pittston, Pennsylvania

21. Signature of Funeral Service Licensee: Tracy A Shuee.
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Amyloidosis — Due to (or as a consequence of): — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Asthma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark S Rosen MD
29c. License number: D 20400
29d. Date signed (Month, Day, Year): 9/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Rosen, Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31110

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Judith H. Magnuson

2. Date of Death: Month October Day 1 Year 1997

3. Time of Death: 9:15 AM

4a. Facility Name (If not institution, give street and number): Genesis Eldercare - Layhill Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 089-24-0072

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 14, 1903

9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13806 Flint Rock Road

10f. Zip Code: 20853

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Secretary

16b. Kind of Business/Industry: Law

17. Father's Name (First, Middle, Last): Gustaf Gustafson

18. Mother's Name (First, Middle, Maiden Surname): Hannah Ohlson

19a. Informant's Neme/Relationship (Type, Print): Claire E. Guertler

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 13806 Flint Rock, Rockville, MD 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 10/4/97

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Robert H. Ramsey

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 3 DAYS

Due to (or as a consequence of):
b. Cerebrovascular Accident — 9 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es a consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colon cancer

Osteo arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyelcian:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature end title of certifier: ▶ [signature]

29c. License number: D18226

29d. Date signed (Month, Day, Year): October 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ARTHUR SCHOENGOLD MD 18111 Prince Philip Dr., OLNEY, MARYLAND 20832

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: ▶ Jesha Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31111

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Opal Murray
2. Dete of Deeth Month / Day / Year: Sept. 30 1997
3. Time of Death: 5:45 AM
4e. Fecility Neme *(If not institution, give street end number)*: 11802 Lovejoy Street
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-78-8560
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 79 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Jan. 7, 1918
9. Birthplece *(State or Foreign Country)*: Tennessee

Usuel Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 11802 Lovejoy Street
10f. Zip Coda: 20902
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 3
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Walter Wright
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Fannie Wells

19e. Informent's Neme/Reletionship *(Type, Print)*: J. Patrick Murray (son)
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 15516 Moravia Court, Derwood, MD 20855

20a. Method of Disposition: 1☒ Burial 2☐ Crametion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Gate of Heaven Cemetery
Dete: 10/3/97
20c. Location - City or Town, Steta: Silver Spring, MD

21. Signeture of Funerel Service Licensee: Steven D Strand
22. Neme end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in deeth): e. Multiple Myeloma — 3 years

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Pert I.: Diabetes

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings evelleble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end mennar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to the causa(s) end mennar stated.

29b. Signeture end title of certifier: Peter B. Sherer MD
29c. License number: D21910
29d. Dete signed *(Month, Dey, Year)*: September 30, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, MD 20906

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 01 1997
32. Registrar's Signeture: Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31112

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Harry	John	Morris	September 27, 1997	2:30 a.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4990 Sentinal Drive #304	Bethesda	Montgomery

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
045-18-6515	1☒ M 2☐ F	75 Yrs.			Sept. 12, 1922	Hartford, CT

Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4990 Sentinel Drive #16-304	20816	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Yaar or Datas: WWII	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
	4+	Counselor Officer	U.S. Department of State

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John G. Morris	Mary Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred Virginia Morris Wife	4990 Sentinal Drive #304, Bethesda, MD 20816

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Mount Comfort Crematory	9/29/97	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Joseph Gawler's Sons, Inc. 5130 WI Avenue, N.W. Washington, D.C. 20016

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ventricular Fibrillation	1 hour
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b. Coronary Artery Disease With Congestive Heart Failure	20 years
	Due to (or as a consequence of): c. Hyperlipidemia	30 years
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residance 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
	DC 14603	September 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Theodore C M Li, M.D. 4910 Massachusetts Avenue, N.W. Washington, D.C. 20016

State Registrar

31. Date filed (Month, Day, Yaar)	32. Registrar's Signature
SEP 30 1997	Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Cleared by Dr. Maple JW

15

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31113

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GREGORY J. MINZIE
2. Date of Death (Month, Day, Year): SEPTEMBER 23, 1997
3. Time of Death: 1015 A
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 096-70-0537
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 4, 1976
9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1 [ ] Yes [X] No
10e. Street and Number: 10026 Forest View Place
10f. Zip Code: 20879
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Fast Food Restaurant

17. Father's Name (First, Middle, Last): Rudolph Minzie
18. Mother's Name (First, Middle, Maiden Surname): Angela Ferguson

19a. Informant's Name/Relationship (Type, Print): Rudolph Minzie (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18660 Sage Way, Germantown, MD 20874

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Fun Srv.
Date: 9/29/97
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Tonya K. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Ruptured hepatic artery aneurysm.	10 hours
Due to (or as a consequence of): b.	Ehlers - Danlos Syndrome.	Congenital
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Von Willebrand's Hemophilia, Disseminated Intravascular Coagulation, Pneumo-hemothorax

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James W. Roley, MD
29c. License number: D50113
29d. Date signed (Month, Day, Year): 9/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JAMES W. ROBEY, MD 5530 WISCONSIN AVE. SUITE 1455 CHEVY CHASE, MD 20815

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31114

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elma Yoder Meyer

2. Date of Death (Month, Day, Year): Sept. 18 1997

3. Time of Death: 7:10 A.M.

4a. Facility Name *(If not institution, give street and number)*: College View Nursing Center

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 162-12-2185

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 11, 1913

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Michigan

10b. County: Kalamazoo

10c. City, Town or Location: Richland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9222 East C.D. Avenue

10f. Zip Code: 49083

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: WWII

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decadent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12) — College (1-4or 5+): 4+

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: U.S. Army

17. Father's Neme *(First, Middle, Last)*: John D. Yoder

18. Mother's Name *(First, Middle, Meiden Surneme)*: Carrie E. Byler

19a. Informent's Neme/Reletionship *(Type, Print)*: John Meyer Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9222 East C.D. Ave., Richland, MI 49083

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Arlington National Cem.

Dete: 10/2/97

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Leon M Peter

22. Neme end Address of Facility: Jos. Gawler's Funeral Home 5130 Wisconsin Ave. NW Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Congestive Heart Failure — years

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contributa to the cauee ot death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medicat Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, dete and pleca, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: Allen J Gilson

29c. License number: D26516

29d. Date signed *(Month, Dey, Year)*: September 18, 1997

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Gilson 1475 Taney Ave. Frederick, Maryland 21702

State Registrar

31. Dete filed *(Month, Dey, Year)*: SEP 29 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

97-5404-033
ML

CALISTA NJOKU

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Calista, NJOKU
2. Date of Death: Month SEPTEMBER Day 20 Year 1997
3. Time of Death: 10:26 PM
4a. Facility Name (If not institution, give street and number): DOCTORS HOSPITAL
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-90-2502
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-16-64
9. Birthplace (State or Foreign Country): Owerri, Nigeria

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georgers
10c. City, Town or Location: Greenbelt
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 6142 Springhill Terrace. Apt#102
10f. Zip Code: 20770
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☒ Yes 2 ☐ No Specify: Nigerian
14. Race - American Indian, Black, White, etc. Specify: African

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Coding Analyst
16b. Kind of Business/Industry: Medical/Hospital

17. Father's Name (First, Middle, Last): Simeon, Eluma, NJOKU
18. Mother's Name (First, Middle, Maiden Surname): Angelina, Nwuiwu

19a. Informant's Name/Relationship (Type, Print): Randy Innis- Brother-In law
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 612 Ransom CT, Odenton, MD, 21113

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery
Date: 9-27-97
20c. Location - City or Town, State: Washington, D.C

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Snead Mortuary Service P.O. Box 5804 cap Hgt Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Asthma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Donald G. Wright MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): SEPTEMBER 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31116

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Loc Thi Nguyen

2. Date of Death — Month: September; Day: 26; Year: 1997

3. Time of Death: 0945 AM

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-11-2322

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Jan. 1, 1926

9. Birthplace *(State or Foreign Country)*: Vietnam

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10906 Cherryvale Court

10f. Zip Code: 20705

10g. Citizen of What Country?: Vietnam

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Nghinh Nguyen

18. Mother's Name *(First, Middle, Maiden Surname)*: Lau Thi Tran

19a. Informant's Name/Relationship *(Type, Print)*: Cuc Thu Le (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4409 Forestville Street #104, Suitland, Maryland 20746

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metropolitan Crematory

Date: 9/28/97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: William L Byrd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory failure	Sudden
Due to (or as a consequence of):	b. Renal failure	Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Hepatic failure	Months
Due to (or as a consequence of):	d. Hepato renal Syndrome	Months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Cirrhosis
- Coronary Artery Disease
-

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SK GUPTA MD

29c. License number: D-32332

29d. Date signed *(Month, Day, Year)*: 09-26-97

30. Name and address of person who completed cause of death (item 23e) (Type, Print): SK GUPTA MD 9801 Georgia Ave #220 SILVER SPRING Md 20902

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Jacki Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RITA LYNNE WEARMAN
2. Date of Death: Month Sept Day 27 Year 1997
3. Time of Death: 10:42 AM
4a. Facility Name (If not institution, give street and number): 2323 Starcrest Drive
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-42-1180
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 52 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 1, 1945
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2323 Starcrest Drive
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Wilbur Dooley
18. Mother's Name (First, Middle, Meiden Surneme): Rita Albright

19a. Informant's Neme/Relationship (Type, Print): (husband) Richard E. Nearman
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2323 Starcrest Drive, Silver Spring, MD 20904

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Metropolitan Crematory
Date: 9/28/97
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: James E Dooley
22. Name and Address of Facility: Franci J. Collins Funeral Home, 500 University Boulevard, West, Silver Spring MD. 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	Gastrointestinal Bleeding	24 hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Wes case referred to medicat exeminer? 1☒ Yes 2☐ No
26. Ptece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and ptece, and due to the cause(s) and manner es stated. 2☒ **Medical Exeminer:** On the basis of exemination end/or investigation, in my optnion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier: John Tauber MD
29c. License number: D08546
29d. Date signed (Month, Dey, Yeer): Sept. 27 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Tauber 8218 Wisconsin Ave Bethesda MD

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31118

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rita Oddone

2. Date of Death Month / Day / Year: 9 / 26 / 97

3. Time of Death: 3:35P

4a. Facility Name *(If not institution, give street and number)*: Potomac Valley Nursing Center

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-22-0820

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 8,1923

9. Birthplace *(State or Foreign Country)*: Wash.,D.C.

Usual Residence of Decedent

10a. State: none

10b. County: none

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4100 W Street, N.W.

10f. Zip Code: 20007

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: executive secretary

16b. Kind of Business/Industry: trade association/ insurance

17. Father's Name *(First, Middle, Last)*: Stephen Sheehy

18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Murphy

19a. Informant's Name/Relationship *(Type, Print)*: Angela Oddone/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 120 A E. Raymond St.,Alexandria, Va. 22301

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Sept,30,97

20c. Location - City or Town, State: Alex., Va.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,N.W.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia of Alzheimers Type

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bipolar Disorder

COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wilhelmina M.D

29c. License number: D21662

29d. Date signed *(Month, Day, Year)*: 9/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wilhelmina G. Camina, M.D.,4912 Adrian St., Rockville, Md. 20853

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 03 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31119

YVONNE PHILLIPS

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
YVONNE REED PHILLIPS	SEPT 26 1997	7:13AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MEMORIAL HOSPITAL	EASTON	TALBOT

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-34-9258	1☐ M 2☒ F	59 Yrs.			FEB. 8, 1938	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	DORCHESTER	HURLOCK	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
106 MAPLETON STREET	21643	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	SOCIAL WORKER	DEPARTMENT OF SOCIAL SERVICES

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH L. REED	MELBA ERA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
PATTI P. SCOTT/DAUGHTER	4736 MILLIGANTOWN ROAD, HURLOCK, MD 21643

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	DORCHESTER MEMORIAL PARK	9/30/97	CAMBRIDGE, MD

21. Signature of Funeral Service Licensee: Leonard D. Zeller

22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary arrest	MINUTES
Due to (or as a consequence of):	b. Sepsis	5 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Wound and anastomotic dehiscence	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure, lupus, ASCVD.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stanley Bysshe

29c. License number: D 23066

29d. Date signed (Month, Day, Year): 9-26-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): STANLEY BYSSHE, M.D., 505 DUTCHMAN'S LANE, EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): OCT - 7 1997

32. Registrar's Signature: Julia Thurlow-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31120

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CAROLYN V. PERRY

2. Data of Deeth Month Day Yaar: SEPTEMBER 28,1997

3. Tima of Death: 10:02 PM

4a. Facility Name (If not institution, give street end number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Daeth: TAKOMA PARK MD

4c. County of Daath: MONTGOMERY CO.

Funeral Director

5. Social Sacurity Numbar: 577-30-4944

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02-07-1919

9. Birthplaca (Stata or Foreign Country): WASHINGTON DC

Usuel Rasidanca of Dacedant

10a. Stata: DC

10b. County:

10c. City, Town or Location: WASHINGTON DC

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Numbar: 1338 D ST. S.E. APT 31

10f. Zip Coda: 20020

10g. Citizan of What Country?: USA

11. Maritai Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highast grada complatad)

Elamantary/Secondary (0-12): 12

Collega (1-4or 5+):

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired): DOMESTIC

16b. Kind of Businass/Industry: PRIVATE

17. Fathar's Name (First, Middla, Last): FLAN ROBINSON

18. Mothar's Nama (First, Middla, Maidan Surnama): ELIZA KING

19a. Informant's Name/Ralationship (Type, Print): JAMES PERRY

19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda): 1353 ALDERTON LANE SILVER SPRING MD 20906

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Steta 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): CEDAR HILL CEMETERY

Data: 10-03-97

20c. Location - City or Town, Stata: SUITLAND MD

21. Signatura of Funaral Service Licensee: ▶ Alex S. Pope JR

22. Nama and Address of Facility: POPE FUNERAL HOME 5538 MARLBORO PIKE, FORESTVILLE MD 20747

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that ceusad tha death. Do not antar the mode of dying, such es cardiac or raspiratory arrest, shock, or heart fallura. List only one ceusa on aach lina.

Approximata Intarval Batwaan Onset end Death

Immediata Ceusa (Final disaasa or condition resulting in daath)

a. CARDIOGENIC SHOCK — ~1 day

Dua to (or as a consaquance of):

Sequantially list conditions, if any, laading to immadiata ceusa. Entar Underlying Cause (Disaasa or injury that initiated evants resulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to complation of cause of daath? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and piace, and dua to tha ceusa(s) and menner steted.

29b. Signeture end title of certifiar: ▶ M. S Nayar

29c. Licensa number: D-17874

29d. Data signad (Month, Day, Year): 9-29-97

30. Nama and addrass of person who completed ceusa of daath (Item 23a) (Type, Print): S. M. NAYAR, MD 3717-38th St BRENTWOOD, MD 20722

State Registrar

31. Data filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signatura: Julia Strickson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucious Pulliam
2. Date of Death (Month, Day, Year): Sept. 23, 1997
3. Time of Death: 12:30 AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-26-8971
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 12, 1912
9. Birthplace (State or Foreign Country): ROXBORO, NC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: CLINTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8501 KEEBLER DRIVE
10f. Zip Code: 20735
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INSPECTOR w/ WASHINGTON GAS CO.
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): ROLAND C. PULLIAM
18. Mother's Name (First, Middle, Maiden Surname): LESSIE WILLIAMS

19a. Informant's Name/Relationship (Type, Print): SHIELA M. WARD-SUMMERS/ DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8501 KEEBLER DR. CLINTON, MARYLAND 20735

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): HARMONY MEMORIAL PARK
Date: 9-30-97
20c. Location - City or Town, State: LANDOVER, MD

21. Signature of Funeral Service Licensee: Guavara L Braxton
22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD, 4308 SUITLAND RD. SUITLAND, MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finai diseese or condition resulting in death):
a. Acute Resp. failure — TWO WKS

Due to (or es a consequence of):
b. AML, CHF Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events reaulting in death) Last

Due to (or as a consequence of):
c. Rec. Hemorrhagic Anemia

Due to (or es e consequence of):
d. Cardiac arrhythmias

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Sub-acute unit

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: attending (MD)
29c. License number: D 24208
29d. Date signed (Month, Day, Year): 9-23-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ABULHASAN U ANSARI MD 8926 Woodyard Rd #101 Clinton MD. 20735

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: John Sheridan-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31122

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE PLENTY JR.

2. Date of Death Month / Day / Year: SEPTEMBER 19, 1997

3. Time of Death: 02:00 PM

4a. Facility Name *(If not institution, give street and number)*: 3522 JEFF ROAD

4b. City, Town, or Location of Death: LANDOVER

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 231-24-7436

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 10 1925

9. Birthplace *(State or Foreign Country)*: NEW YORK

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: LANDOVER

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3522 JEFF ROAD

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Collage (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LAWYER

16b. Kind of Business/Industry: SELF EMPLOYED

17. Father's Name *(First, Middle, Last)*: GEORGE RICHARD PLENTY SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: EDITH EDMONDS

19a. Informant's Name/Relationship *(Type, Print)*: BRUCE GREEN-STEPSON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 700 7TH STREET, SW #114 WASHINGTON, D.C. 20024

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CHELTENHAM MEMORIAL CEM

Date: OCT 1 97

20c. Location - City or Town, State: CHELTENHAM, MD

21. Signature of Funeral Service Licensee: W. H. Bacon 276

22. Name and Address of Facility: W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, NW WASHINGTON, D.C. 20010

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: PME

29c. License number: D 33954

29d. Date signed *(Month, Day, Year)*: SEPTEMBER 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR. MD, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Data filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Gloria Sheridan Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

97-5429-031
ML

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31123

ANTHONY HAYDEN Amended #'s 10c.19b.PGC 9/30/97 *Certificate of Death* cr

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAYDEN ANTHONY PURCELL-PILGRIM
2. Date of Death Month Day Year: SEPTEMBER 22 1997
3. Time of Death: 11:36 PM
4a. Facility Name *(If not institution, give street and number)*: ERSKINE AND NEW HAMPSHIRE AVENUE
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-19-0143
6. Sex: XX 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 18 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 9-24-79
9. Birthplace *(State or Foreign Country)*: WASHINGTON,D.C.

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: HYATTSVILLE ~~6526 PARKWAY CT.HAYETTSVILLE,MD. 20782~~
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6526 PARKWAY CT
10f. Zip Code: 20782
10g. Citizen of What Country?: U.S.A.

11. Marital Status: XX 1 Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No Specify: AFRO-AMERICAN
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+)
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STUDENT
16b. Kind of Business/Industry: HIGH SCHOOL

17. Father's Name *(First, Middle, Last)*: JAMES PILGRIM
18. Mother's Name *(First, Middle, Maiden Surname)*: THERESA PURCELL

19a. Informant's Name/Relationship *(Type, Print)*: THERESA PURCELL
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6526 PARKWAY CT. ~~HAYETTSVILLE~~ HYATTSVILLE,MD.20782

20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FT. LINCOLN CEMETERY
Date: 9/27/97
20c. Location - City or Town, State: BLADENBURG MD.

21. Signature of Funeral Service Licensee: James E. Williams 799
22. Name and Address of Facility: THE HOUSE OF WILLIAMS FUNERAL SERVICE 411 KENNEDY STREET N.W.WASHINGTON,D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings aveliable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was cese referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of injury *(Month, Day Year)*: 9/22/97
28b. Time of injury: 2336HR M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject was passenger of vehicle and was ejected
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: roadway
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Erskine and New Hampshire Avenue in Takoma Park, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted.
29b. Signeture and title of certifier: Theodore M. King
29c. License number: O.C.M.E.
29d. Dete signed *(Month, Day, Year)*: SEPTEMBER 23, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 30 1997
32. Registrar's Signature: John Thurston Randall

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31124

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vincent Vito Poskus

2. Date of Death Month Day Year: September 26, 1997

3. Time of Death: 2:47 AM

4a. Facility Name *(If not institution, give street and number)*: Atlantic General Hospital

4b. City, Town, or Location of Death: Berlin

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 031-22-9525

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 2, 1931

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Ocean City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 606 Dory Road #204

10f. Zip Code: 21842

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Office Manager

16b. Kind of Business/Industry: HVAC

17. Father's Name *(First, Middle, Last)*: James Poskus

18. Mother's Name *(First, Middle, Maiden Surname)*: Marcella Sakalauskas

19a. Informant's Name/Relationship *(Type, Print)*: Sara Jane Poskus/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 606 Dory Road, #204, Ocean City, Maryland 21842

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. Date: October 1, 1997

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Jane M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE Myocardial Infarction — 1/2 to 1 HR

Due to (or as a consequence of):

b. Atherosclerotic HEART Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George J DiRago, MD

29c. License number: D51677

29d. Date signed *(Month, Day, Year)*: September 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George J. DiRago, M.D. 9733 Healthway Drive, Berlin, Maryland 21811

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Amend #8, 10/2/97, BMW, Mongt.Co.perF.H. — *Certificate of Death* — Reg. No. 97 31125

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Euna S. Palmer
2. Date of Death Month Dey Yeer: September 28, 1997
3. Time of Death: 3:05 PM
4a. Facility Neme *(If not institution, give street end number)*: Rockville Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 534-22-0285
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: ~~Feb. 26, 1997~~ Feb. 26, 1925
9. Birthplace *(State or Foreign Country)*: Washington

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 303 Adclare Road
10f. Zip Code: 20850
10g. Citizen of Whet Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): ; Collage (1-4or 5+): 4
16e. Dacedent's Usuel Occupetion *(Give kind of work done duning most of working life. DO NOT use ratired)*: Secretary
16b. Kind of Business/Industry: University
17. Father's Name *(First, Middle, Last)*: David Leon Petway
18. Mother's Neme *(First, Middle, Malden Surneme)*: Geraldine Ruth Burns
19a. Informent's Name/Reletionship *(Type, Print)*: Alyson Palmer / daughter
19b. Mailing Addrass *(Streat end Number or Rurel Routa Number, City or Town, State, Zip Coda)*: 74 2nd Avenue, Apt. 2-A, New York, NY 10003-8658
20e. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: Montgomery Crematorium, Inc. — Dete: September 30, 1997
20c. Location - City or Town, State: Bethesda, Maryland
21. Signeture of Funerel Service Licensee: Barbara Jo McMullen Lawrence — M00831
22. Neme and Address of Facility: Robert A. Pumphrey Funeral Home / Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errast, shock, or heert feilure. List only one ceuse on eech lina.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final diseesa or condition resulting in daath)
e. Breast Cancer — Years

Dua to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate ceusa. Enter Underlying Ceuse (Disaese or injury thet initiated events resulting in deeth) Last
b.
Dua to (or es e consaquence of):
c.
Due to (or as e consequenca of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure, Deep Vein Thrombosis, Hypertension, Multiple Sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicel exeminar? 1☐ Yes 2☒ No

26. Pleca of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Mannar of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28e. Data of Injury *(Month, Dey Year)*
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28e. Placa of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, data and piece, end due to tha cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, daath occurred et the time, deta end place, end dua to tha cause(s) end manner steted.

29b. Signature and title of certifier: David A. Blass MD
29c. License number: D23911
29d. Dete signed *(Month, Day, Year)*: September 30, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): David A. Blass, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814-1700

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31126

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Mary Plackett

2. Date of Death Month Day Year: September 23, 1997

3. Time of Death: 10:44 AM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Locafion of Deeth: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 218-30-4049

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 12, 1906

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 19310 Club House Road #504

10f. Zip Code: 20879

10g. Citizen of What Country?: United States

11. Marital Stefus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedenf's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Nursing

17. Father's Neme *(First, Middle, Last)*: Charles Givens

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Charlotte Burroughs

19a. Informanf's Name/Relationship *(Type, Print)*: Patricia A. Piedmonte/Daughter

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 404 Church Street, Syracuse, New York 13209

20a. Mefhod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery | Date: Sept. 26, 1997

20c. Location - City or Town, State: Brentwood, Maryland

21. Signafure of Funeral Service Licensee: Ray Faust M00198

22. Name end Address of Facility: Robert A. PUmphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiiure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Cardio-pulmonary Arrest	Minutes
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last b.	Hypovolemic Shock	Hours
Due to (or as a consequence of):		
c.	Hemorrhagic Coagulopathy	Hours
Due to (or as a consequence of):		
d.	Ruptured Abdominal Aortic Aneurysm	Hours

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did **tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior fo completion of cause of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signature and fitle of certifier: Robert Fox

29c. License number: D24773

29d. Dete signed *(Month, Dey, Year)*: September 24, 1997

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Robert L. Fox, M.D. 9715 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALICE M. PEGRAM
2. Data of Death Month Day Year: Sept. 26, 1997
3. Time of Death: 12:38 A
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 229-16-9263
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept.4, 1908
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 215 Thistle Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:
13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): William Fields
18. Mother's Neme (First, Middle, Meiden Surname): Louisa Claiborn

19a. Informant's Name/Relationship (Type, Print): Louise Williams (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 215 Thistle Dr., Silver Spring, MD 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cem.
Date: 10/1/97
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: George R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS

Due to (or as a consequence of):
b. PNEUMONIA ASPIRATION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): /
c.

Due to (or as a consequence of):
d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
MALNUTRITION, DEMENTIA, CEREBROVASCULAR ACCIDENT(S)

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Elliot R Goldstein
29c. License number: D03581
29d. Date signed (Month, Day, Year): SEPT 26th 1997

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Elliot R. Goldstein, M.D. 9410 Old Georgetown Rd., Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31128

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn L. Reaver

2. Date of Death: Month Sept. Day 29 Year 1997

3. Time of Death: 4:45 p.m.

4a. Facility Name (If not institution, give street and number): North Hampton Manor

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-70-0460

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): Sept. 4, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 200 East 16th Street

10f. Zip Code: 21701

10g. Citizen of What Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): J. Edward Schellar

18. Mother'a Neme (First, Middle, Maiden Surneme): Annie Bart

19a. Informant's Neme/Relationship (Type, Print): Betty Stephens Daughter

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 11902 Beaver Dam Road Union Bridge, MD 21791

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other placa): Linganore Cemetery

Date: Oct. 2

20c. Location - City or Town, State: Unionville, Maryland

21. Signature of Funeral Service Licensee: James B. Covey

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): a. Renal Failure — DAYS

Due to (or as a consequence of): DEHYDRATION — 3 DAYS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(a) and manner steted.

29b. Signeture and title of certifier

29c. License number: D43091

29d. Date signed (Month, Dey, Yeer): 10-1-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAEED QADI 801 TOLL HOUSE AVE, FREDERICK 21701

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Stuntzer Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31129

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Jeannette F. Reardon
2. Dete of Deeth — Month: September Dey: 26 Yeer: 1997
3. Time of Death: 3:00 A. M.
4e. Facility Neme (If not institution, give street and number): Bradford Oaks Nursing Center
4b. City, Town, or Location of Deeth: Clinton
4c. County of Deeth: Prince George's

Funeral Director

5. Sociel Security Number: 577-12-7085
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. lest birthdey): 78 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Aug. 6, 1919
9. Birthplece (Stete or Foreign Country): North Carolina

Usuel Residence of Decedent

10e. Stete: Maryland — 10b. County: Prince George's — 10c. City, Town or Location: Temple Hills — 10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3712 - 26th Avenue — 10f. Zip Code: 20748 — 10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): File Clerk
16b. Kind of Business/Industry: IBEW Union

17. Fether's Neme (First, Middle, Last): James R. Fortune
18. Mother's Neme (First, Middle, Meiden Surname): Annettie Green

19e. Informent's Name/Reletionship (Type, Print): Virginia Quimby/Sister
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3505 - 29th Pl., Temple Hills, Md. 20748

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Ft. Lincoln Cemetery — Dete: 9/30/97
20c. Locetion - City or Town, Stete: Brentwood, Maryland

21. Signeture of Funerel Service Licensee: George P. Kalas
22. Neme end Address of Fecility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md.20745

Physician /Medical Examiner

23e. Pert I. Enter the diseese or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. TERMINAL PULMONARY EMBOLISM — 24 HRS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
b. Due to (or es a consequence of):
c. Due to (or es e consequence of):
d.

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.: COPD / SEIZURES / BREAST NEOPLASM

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☑ Yes 2☐ No

28. Plece of Deeth (Check only one) — Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ Medical Exeminer: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Michael Levine, M.D.
29c. License number: D24945
29d. Dete signed (Month, Dey, Yeer): Sept 29, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Michael Levine, M.D. 7801 Old Branch Ave. Clinton, Md. 20735

State Registrar

31. Dete filed (Month, Dey, Yeer): SEP 29 1997
32. Registrar's Signeture: Julie Drucker-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31130

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William L. Renner

2. Date of Death Month / Day / Year: Sept. 24 1997

3. Time of Death: 10:55 P.M.

4a. Facility Name *(If not institution, give street and number)*: Larkin Chase Nursing Center

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 214 05 4071

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 29, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: ☒ 1 Yes 2 ☐ No

10e. Street and Number: 6617 23rd Place

10f. Zip Code: 20782

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? *(Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)* 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Linotype Operator

16b. Kind of Business/Industry: G.P.O.

17. Father's Name *(First, Middle, Last)*: Unavailable Renner

18. Mother's Name *(First, Middle, Maiden Surname)*: Unavailable

19a. Informant's Name/Relationship *(Type, Print)*: Robert Renner Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1453 Harwell Ave. Crofton Maryland 21114

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland National Cemetery Date: Sept. 27, 1997

20c. Location - City or Town, State: Laurel Maryland

21. Signature of Funeral Service Licensee: Michael L Bigler

22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 1 Day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sipli MD

29c. License number: D45560

29d. Date signed *(Month, Day, Year)*: Sept 25 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 30601 Mitchellville Rd. Bowie Maryland 20716

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31131

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES R. ROEDER
2. Data of Death Month/Day/Yaar: SEPT. 29, 1997
3. Tima of Deeth: 6:30 AM
4a. Facility Nama (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY COUNTY

Funeral Director

5. Social Security Number: 577-42-5524
6. Sax: 1☒ M 2☐ F
7. Aga (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): MAY 11, 1931
9. Birthplaca (Stata or Foraign Country): WASHINGTON, DC

Usual Rasidance of Dacedant

10a. State: MARYLAND
10b. County: PRINCE GEORGES
10c. City, Town or Location: ADELPHI
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2701 PHILBEN DRIVE
10f. Zip Coda: 20783
10g. Citizan of What Country?: UNITED STATES

11. Maritel Stetus: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad
12. Was Dacedent Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Give Yaar or Datas: 7/1951 6/1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:
14. Race - Amaricen Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Spacify only highest grade complatad): Elamantary/Secondary (0-12): 12; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): AIR TRAFFIC CONTROLLER
16b. Kind of Businass/Industry: FEDERAL GOVERNMENT

17. Fathar's Nama (First, Middle, Last): CHARLES A. ROEDER
18. Mothar's Nama (First, Middle, Maidan Surnama): IVA E. FOREACRE

19a. Informant's Name/Ralationship (Type, Print): MARGIE R. ELLIS, SISTER
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 6402 LONE OAK DRIVE, BETHESDA, MARYLAND 20817

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)
20b. Place of Disposition (Nama of camatary, cramatory or othar place): FORT LINCOLN CEMETERY
Data: 10/2/97
20c. Location - City or Town, Stata: BRENTWOOD, MARYLAND

21. Signature of Funaral Sarvica Licensee: Dana Grant
22. Nama and Addrass of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona ceusa on aach lina. — Approximata Intarval Batwaen Onsat and Daath

Immadiata Causa (Final disaasa or condition resulting in daath):
a. METASTATIC CANCER PRIMARY UNKNOWN
Dua to (or as a consaquanca of):
b. LUNG CANCER

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. Othar significant conditions contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to compiation of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to madical examinar? 1☐ Yas 2☒ No
26. Placa of Daath (Check only ona): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)
27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ Cartifying Physician: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ Madical Examinar: On tha basis of examinetion & invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha ceusa(s) and mannar as statad.
29b. Signatura and titla of cartifiar: A. Dashottar
29c. Licansa number: D 25977
29d. Data signad (Month, Day, Yaar): 9.29.97

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): AJAY DASHOTTAR, M.D., 7207 HANOVER PARKWAY, #A, GREENBELT, MARYLAND 20770

State Registrar

31. Data filad (Month, Day, Yaar): OCT 08 1997
32. Registrar's Signatura: Robin Strader Rockell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31132

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet Elaine Russell

2. Date of Death: Month 09 Day 20 Year 1997

3. Time of Death: 06:40 PM

4a. Facility Name (If not institution, give street and number): Heartland of Hyattsville

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-68-4048

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01 20 1951

9. Birthplace (State or Foreign Country): Dist of Columbia

Usual Residence of Decedent

10a. State: D. C.

10b. County: N/A

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 410 Fifteenth Street, Northeast #4

10f. Zip Code: 20003

10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Officer

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Richard Thorne

18. Mother's Name (First, Middle, Maiden Surname): Addie Logan

19a. Informant's Name/Relationship (Type, Print): Roslyn Russell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 410 - 15th St., NE., Washington, D. C. 20003

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverdale Crematory

Date: 9/30/97

20c. Location - City or Town, State: Riverdale, Maryland

21. Signature of Funeral Service Licensee: #810

22. Name and Address of Facility: Lawrence W. Plunkett, Inc. Funeral Home 2504 - 28th St., NE., Wash., D. C. 20018-1413

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c. Asthma

Due to (or as a consequence of):

d. Respiratory Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: MD

29c. License number: D 42019

29d. Date signed (Month, Day, Year): OCT 8TH 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IMRAN CHOWDHURY MD 7350 VAN DUSEN Rd LAUREL MD 20707

State Registrar

31. Date filed (Month, Day, Year): OCT 09 97

32. Registrar's Signature: Jobi Mudson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31133

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Abraham David Rubinstein
2. Date of Death (Month, Day, Year): Sept. 23, 1997
3. Time of Death: 5:00pm
4a. Facility Name (If not institution, give street and number): Genesis Elder Care Layhill Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-48-0784
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 15, 1902
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 3310 N. Leisure World Blvd.
10f. Zip Code: 20906
10g. Citizen of Whel Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Merchant
16b. Kind of Business/Industry: Groceries

17. Fether's Name (First, Middle, Last): Solomon Rubinstein
18. Mother's Name (First, Middle, Maiden Surname): Bessie Balin

19a. Informant's Name/Relationship (Type, Print): Herbert Rubinstein/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5450 Whitley Park Terr. Bethesda, Md 20814

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Judean Mem. Gdns.
Date: 9/25/97
20c. Location - City or Town, State: Olney, Md

21. ~~Signature~~ of Funeral Service Licensee: Peter L. Hamm
22. Name end Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebrovascular Accident	3 days
Due to (or as a consequence of): b.	Pneumonia	3 days
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in death) Last — Due to (or as a consequenca of): c.		
Due lo (or es e consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

gastrostomy
Diabetes
Dysphagia
Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D18726
29d. Date signed (Month, Day, Year): September 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Matthew Schoengold, M.D. 811 Prince Phillip Dr, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31134

Amend #10e, 10/3/97, BMW, Montg.Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John Francis Regan	Sept. 27, 1997	5:35PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6001 Osceola Rd.	Bethesda	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
539-07-4512	1☒M 2☐F	79 Yrs.			Aug. 18, 1918	Montana

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Bethesda	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6001 Osceola Road ~~6001 Osceola Rd.~~	20816	U.S.A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	5+	Director of Management Education	C & P Telephone

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Thomas J. Regan	Mary Hurley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Martha Moore Regan-Wife	6001 Osceola Rd. Bethesda, MD 20816

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Mt. Comfort Crematory	9/30/97	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	Joseph Gawler's Sons INC 5130 Wisconsin Ave. NW Washington, DC 20016

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Metastatic Lung Cancer	4 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D-33293	September 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick P. Smith MD., 5401 Western Ave. NW Washington, DC 20015-2998

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician**: This law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
SEP 30 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31135

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Haldor Enger Rosvold
2. Date of Death (Month, Day, Year): September 26, 1997
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): 15101 Interlachen Drive, #915
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 046-26-4197
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1916
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 15101 Interlachen Drive, #915
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Scientist
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Ludwig Rosvold
18. Mother's Name (First, Middle, Maiden Surname): Margit Enger

19a. Informant's Name/Relationship (Type, Print): Mary Rosvold, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15101 Interlachen Dr., #915 Silver Spring, MD 20906

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: Sept 29, 1997
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Harry M. Grier
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Parkinson Disease	5 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Gastrointestinal Bleeding	3 DAys
Due to (or as a consequence of):		
c.	urosepsis	3 DAys
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Gastrostomy
Dysphagia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D18726
29d. Date signed (Month, Day, Year): September 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Arthur Schoengold, MD. 8111 Prince Phillip Dr, Olney, MD 20832

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997
32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Cleared/Released by Dr. Tauber, M.E., 9/26/97

10

JW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31136

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nora E. Richards
2. Date of Death (Month, Day, Year): September 24, 1997
3. Time of Death: 10:05PM
4a. Facility Name (If not institution, give street and number): 8100 Connecticut Avenue, #1501
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-62-3473
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 28,1903
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8100 Connecticut Avenue, #1501
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Herbert Marsden
18. Mother's Name (First, Middle, Maiden Surname): Henrietta de Jongh

19a. Informant's Name/Relationship (Type, Print): Celia H. Josephs- Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4845 V Street, N.W., Washington, DC 20007

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: September 25,1997
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: M00689
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. METASTATIC CARCINOMA OF THE BLADDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. Licensa number: D26571
29d. Date signed (Month, Day, Year): September 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Irving Mizus, M.D. 4930 Del Ray Avenue, #301, Bethesda, Maryland 20814

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31137

16

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lura Gay Samakow
2. Data of Daeth (Month, Day, Yaar): October 4, 1997
3. Tima of Death: 4:30 PM
4a. Facility Name (If not institution, give street end number): 4245 Robinson Neck Road
4b. City, Town, or Location of Death: Taylors Island
4c. County of Death: Dorchester

Funeral Director

5. Social Security Numbar: 453-48-5212
6. Sex: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): July 6, 1935
9. Birthplace (State or Foreign Country): New Mexico

Usual Residance of Dacedant

10a. Steta: Maryland
10b. County: Dorchester
10c. City, Town or Location: Taylors Island
10d. Insida City Limits: 1☐ Yaa 2☒ No
10e. Street and Number: 4245 Robinson Neck Road
10f. Zip Coda: 21669
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No — If Yas, Giva Year or Datas: 1956 1962
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decadent's Education (Specify only highast grada completed): Elamentary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired): Accountant
16b. Kind of Buainass/Industry: Federal Government

17. Father's Name (First, Middle, Last): Bernard Roosevelt Willhite
18. Mother's Nama (First, Middle, Maiden Sumama): Sybil Willis

19a. Informant's Name/Relationship (Type, Print): Jack Samakow Husband
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda): P.O. Box 192 Taylors Island, Maryland 21669

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Neme of camatary, cramatory or other piaca): Md Veterans Cemetery
Data: 10/7/97
20c. Location - City or Town, Stata: Hurlock, Maryland

21. Signature of Funeral Sarvica Licansaa: [signature]
22. Nama and Address of Facility: Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad the daath. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Intarval Between Onset and Daath

Immediata Cause (Final disaasa or condition rasulting in daath): a. Malignant Lymphoma — 9 months
Dua to (or as a consequance of):
Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Diseasa or Injury thet initiatad avents rasulting in daath) Last: b. Dua to (or as a consequance of): c. Due to (or as a consequanca of): d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yes 2☒ No

25. Was casa raferred to medical examinar? 1☐ Yas 2☒ No
26. Placa of Daath (Chack only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Residanca 6☐ Othar (Specify)
27. Manner of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Time of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Cartifying Physician**: To the bast of my knowledga, daath occurrad at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ **Madical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. Licansa number: D26278
29d. Date signed (Month, Day, Year): 10-6-97
30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): David Cavell, MD 145 E. Carroll St. Salisbury, MD 21801

State Registrar

31. Data filad (Month, Day, Yaar): OCT 6 1997
32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Victoria Spruels

2. Date of Death Month: October Dey: 01 Yaer: 1997

3. Time of Death: 17:03

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 216-14-9972

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Houra / Min.

8. Date of Birth (Month, Dey, Yaar): JAN. 26, 1919

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Dacedant

10a. Stete: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☑ Yas 2☐ No

10a. Street and Number: 706-Moores Avenue

10f. Zip Code: 21613

10g. Citizen of What Country? USA

11. Meritel Stafus: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yas, Giva Yaar or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 1 College (1-4or 5+):

16a. Decedent's Usuel Occupafion (Give kind of work done during most of working life. DO NOT use retired): Factory-Line Worker

16b. Kind of Business/Industry: Seafood Industry

17. Fether's Nama (First, Middle, Last): Ozzie Morgan

18. Mother's Neme (First, Middla, Meiden Surneme): Lena Whitaker

19a. Informent's Neme/Reletionship (Type, Print): Gladys L. Camper

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 708 Moores Avenue Cambridge, MD. 21613

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cematary, crematory or other place): Veterans Cemetery

Date: 10/8/97

20c. Location - City or Town, Stete: Hurlock, Maryland

21. Signature of Funaral Service Licensee: ▶ Janelle C. Henry

22. Neme end Address of Facility: Henry Funeral Home 510 Washington St. Cambridge, MD. 21613

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complicetions thet caused the death. Do not anter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death): e. Pneumonia — 2 weeks

Due to (or as a consequence of): b. Emphysema — 5 Years

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted avants resulting in death) Last: Due to (or es a consequence of): c. Renal Failure — 3 Months

Due to (or as a consequance of): d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Piece of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Othar (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, date end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and mennar steted.

29b. Signature and title of certifier: ▶ William Bair

29c. Licensa number: D 43238

29d. Dete signed (Month, Dey, Yaar): 10/1/97

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): William Bair 19 Franklin St. Cambridge, MD

State Registrar

31. Dete filed (Month, Dey, Yaar): OCT 6 1997

32. Registrar's Signature: Julia Thurlow-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mamie I. Smith

2. Date of Death (Month, Day, Year): September 30, 1997

3. Time of Death: 11:30 AM

4e. Facility Name (If not institution, give street and number): Westminster Nursing Home

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 415-38-1265

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 14, 1915

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10e. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 929 Washington Road

10f. Zip Code: 21157

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): worker

16b. Kind of Business/Industry: clothing factory

17. Father's Name (First, Middle, Last): Dewitt Roberts

18. Mother's Name (First, Middle, Maiden Surname): Lizzie Jane Cruse

19a. Informant's Name/Relationship (Type, Print): Brenda Thomas, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 929 Washington Rd., Westminster, MD 21157

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Gardens | Date: 10/02/97

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: Katherine Spitts - Switzer

22. Name and Address of Facility: Spitts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CEREBRO VASCULAR ACCIDENT — 10 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

EMPHYSEMA / PNEUMONIA

PARKINSON'S DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28e. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ATTENDING PHYSICIAN

29c. License number: D21155

29d. Date signed (Month, Day, Year): 10/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARTHUR L. RUDO, MD 904 WASHINGTON RD WESTMINSTER MD 21157

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Janice Strickler Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31140

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Verdell G. Smith

2. Data of Death: Month 09 Day 25 Yaar 97

3. Tima of Death: 12:37 pm

4a. Facility Neme (If not institution, giva street and number): 801 Metzerott Rd. Heartland Health Care of Adelphi

4b. City, Town, or Location of Deeth: Adelphi

4c. County of Deeth: P.G.

Funeral Director

5. Social Security Number: 262-40-6163

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): 4-17-15

9. Birthplace (State or Foreign Country): Georgia

Usual Rasidance of Dacedent

10a. State: MD.

10b. County: Prince George

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street end Number: 6500 Riggs Road

10f. Zip Code: 20783

10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forces? 1☐ Yas 2☐ No If Yas, Giva Yaar or Detes:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired): Postage Coiler

16b. Kind of Business/Industry: Federal Government

17. Fathar's Name (First, Middle, Last): John Towns

18. Mothar's Nema (First, Middle, Maidan Sumama): Cora (unknown)

19a. Informant's Name/Relationship (Type, Print): Doloris S. Brown - Daughter

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 9605 Beachwood Ave., Lanham, MD. 20706

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or other place): Ft. Lincoln Cemetery Date: 10-1-97

20c. Location - City or Town, Stete: Brentwood, MD.

21. Signatura of Funerel Service Licensee: Alexander L. Pope, Jr.

22. Nama and Address of Facility: Pope Funeral Homes 5534 Marlboro Pike, Forestville, MD 20747

Physician /Medical Examiner

23a. Pert1. Entar tha disaese, or complications that caused the death. Do not antar the moda of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediete Causa (Final disaasa or condition resulting in deeth): a. Arteriosclerotic Cardiovaswlar Disease years

Dua to (or es e consequance of):

Sequentially list conditions, if any, leading to immedieta causa. Entar Underlying Cause (Disaase or Injury that initieted evants resulting in death) Last:

b. Dua to (or as e consequance of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

End Stage Renal Disease

Temporo parietal Mass type indeterminant

Arterial hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only ona)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year): N/A

28b. Tima of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, date and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, and dua to tha cause(s) and mannar statad.

29b. Signature and title of certifiar

29c. License number: D01852

29d. Date signed (Month, Day, Year): September 25 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A DeVore MD 4203 Queensbury Rd Hyattsville MD 20781

State Registrar

31. Data filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: John Sheridan Rardell

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31141

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Josepha Schmid
2. Date of Death Month Day Year: September 26, 1997
3. Time of Death: 8:00 AM
4a. Facility Name *(If not institution, give street and number)*: Pineview Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-46-1200
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 24, 1901
9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax County
10c. City, Town or Location: Alexandria
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6641 Wakefield Drive, Apt. 602
10f. Zip Code: 22307
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Hans Laendner
18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Gruber

19a. Interment's Name/Relationship *(Type, Print)*: Evelyn Blatnik/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6641 Wakefield Dr. #602, Alexandria, Va. 22307

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery | Date: 9/29/97
20c. Location - City or Town, State: Resurrection Cemetery

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. ASCAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*: NA
28b. Time of Injury: NA M
28c. Injury at Work? 1☐ Yes 2☐ No: NA
28d. Describe how injury occurred: NA
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: NA
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: NA

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D45881
29d. Date signed *(Month, Day, Year)*: September 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carl Johnson, M.D. 700 Old Line Center Suite 207 Waldorf, Md. 20602

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997
32. Registrar's Signature:

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31142

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ida Davenport Swingle

2. Date of Death Month Day Year: September 16, 1997

3. Time of Death: 8:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: 11424 Hawk Ridge Court

4b. City, Town, or Location of Death: Beltsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-62-9348

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 2, 1906

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11424 Hawk Ridge Court

10f. Zip Code: 20705

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4 or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: Hazy Davenport

18. Mother's Name *(First, Middle, Maiden Surname)*: Nora Ann King

19a. Informant's Name/Relationship *(Type, Print)*: George E. Digel/Guardian

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 556 Whispering Meadows Dr. Westminster, MD 21158

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metropolitian Crematory | Date: Sept. 18, 1997

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Bryan D. Newblatt

22. Name and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. URINARY SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the besis of exemination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifier: John A. Eastone, M.D.

29c. License number: MD0000028855

29d. Date signed *(Month, Day, Year)*: September 18, 1997

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print): John A. Eastone, M.D. NNMC 8901 Wisconsin Ave. Bethesda, MD 20889

State Registrar

31. Data filad *(Month, Day, Year)*: SEP 30 1997

32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

5

97 31143

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gillie Neal Louise Salter

2. DATE OF DEATH (Month, Day, Year): September 20, 1997

3. TIME OF DEATH: 11:43PM M

4. SOCIAL SECURITY NUMBER: 241-50-0780

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 86 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): March 7, 1911

8. BIRTHPLACE (State or Foreign Country): North Carolina

9a. FACILITY NAME (If not institution, give street and number): Doctor's Community Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Lanham

9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: North Carolina

10b. COUNTY: Guilford

10c. CITY, TOWN OR LOCATION: Greensboro

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 3707 Holts Chapel Road

10f. ZIP CODE: 27401

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4 or 5+): 4 years

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired RN Nurse

16b. KIND OF BUSINESS/INDUSTRY: Medical

17. FATHER'S NAME (First, Middle, Last): Carter Neal

18. MOTHER'S NAME (First, Middle, Maiden Surname): Lelia B. Graves

19a. INFORMANT'S NAME (Type/Print): Charlene S. Adams/Lelia Gore

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3146 Wild Azalea Way-Southport, North Carolina

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Piedmont Cemetery

DATE: 9/26

20c. LOCATION — City or Town, State: Greensboro, NC

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thos. M. Latney Funeral Home

22. NAME AND ADDRESS OF FACILITY: Latney's Funeral Home
3831 Georgia Avenue, N. W. Wash. D. C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic breast cancer — 2 years
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____
DUE TO (OR AS A CONSEQUENCE OF):
c. _____
DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Tanya C Lumpkins MD

29c. LICENSE NUMBER: MD44321

29d. DATE SIGNED (Month, Day, Year): Sept. 21, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tanya C. Lumpkins 9500 Annapolis Road Suite A1 Lanham Maryland 20706

31. DATE FILED (Month, Day, Year): SEP 30 1997

32. REGISTRAR'S SIGNATURE: Julia Sheridan Randall

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31144

Amended #2 100397 PGCH ELM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Smith

2. Date of Death: Month September Day ~~30~~ 29 Year 1997

3. Time of Death: 9:10 pm

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 579-16-4599

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 2, 1905

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3104 Lancer Drive

10f. Zip Code: 20782

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Tait

18. Mother's Name (First, Middle, Maiden Surname): Mabel Patton

19a. Informant's Name/Relationship (Type, Print): Nancy Trainer - Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3104 Lancer Drive, Hyattsville, Maryland 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: 10/03/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: W. B Geesey

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pulmonary embolism — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles W. Phelps MD

29c. License number: D41816

29d. Date signed (Month, Day, Year): 9/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles W. Phelps MD, c/o AAMC 64 Franklin St., Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(2)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31145

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Stearns
2. Date of Death (Month, Day, Year): Sept. 25, 1997
3. Time of Death: 8:50pm
4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-60-7039
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1906
9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6121 Montrose Road
10f. Zip Code: 20852
10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Wife
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Edward Cooper
18. Mother's Name (First, Middle, Maiden Surname): Jennie Miller
19a. Informant's Name/Relationship (Type, Print): Beverly Cohen-Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3310 N. Leisure World Blvd 315 Silver Spring, MD 20906
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Adas Israel Cemetery
Date: 9/28/97
20c. Location - City or Town, State: Washington DC
21. Signature of Funeral Service Licensee: Daniel Simons
22. Name and Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Urethral Carcinoma — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Burt Feldman MD
29c. License number: D23958
29d. Date signed (Month, Day, Year): 9/26/97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Burt I. Feldman MD, 6105 Montrose Rd., Rockville MD 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997
32. Registrar's Signature: Julia Davidson-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adelaide L. Smith

2. Date of Death (Month, Dey, Year): September 24, 1997

3. Time of Death: 4:00 PM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 264-80-2518

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 101 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): July 26, 1896

9. Birthpiece (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 211 Russell Avenue

10f. Zip Code: 20877

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

Collage (1-4or 5+): 1

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk

16b. Kind of Business/Industry: Veterans Administration

17. Fether's Name (First, Middle, Last): Forrest Leigh

18. Mother's Name (First, Middle, Meiden Surneme): Victoria Bland

19a. Informent's Neme/Reletionship (Type, Print): Winifred H. Welsh/Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4805 Edgefield Road, Bethesda, Maryland 20814

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Fort Lincoln Crematory

Dete: 9/27/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signeture of Funeral Service Licensee: Andrew J. Hines

22. Neme end Address of Feciliity: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feiiure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth): e. Sepsis — 24 hrs

Due to (or es e consequenca of):

Sequentieily iist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medicai examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Couid not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medicel Examiner:** On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: Thomas J. McNamara

29c. License number: D32610

29d. Date signed (Month, Dey, Year): September 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Thomas J. McNamara, M.D. 5602 Shields Drive, Bethesda, Maryland 20817

State Registrar

31. Dete filed (Month, Dey, Year): SEP 30 1997

32. Registrer's Signature: Lelia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Adelaide Smith 1680 SEP 24 1997

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31147

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia Schneider

2. Date of Death Month / Day / Year: September 26 1997

3. Time of Death: 1:15PM

4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220-40-4220

6. Sex: 1☐ M XX F

7. Age *(In yrs. last birthday)*: 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct.10,1941

9. Birthplace *(State or Foreign Country)*: Washington,D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Beltsville

10d. Inside City Limits: 1☐ Yes 2XX No

10e. Street and Number: 4806 Garrett Avenue

10f. Zip Code: 20705

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No *Specify:*

14. Reca - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Albert M. Elksnis

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith LaFever

19a. Informant's Name/Relationship *(Type, Print)*: Ludwig A. Schneider (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4806 Garrett Avenue Beltsville, Maryland 20705

20a. Method of Disposition: XX 1 Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: 9/30/1997

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Fecility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finai disease or condition resulting in death)

a. Sepsis with Septic Shock

Due to (or es a consequenca of):

b. Acute Respiratory Failure

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last

Due to (or as a consequence of):

c. Carcinoma of the Larynx

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturai 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D13687

29d. Date signed *(Month, Day, Year)*: 9-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph D. Maddy, MD PA

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31148

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROSETTA J. SAUNDERS
2. Date of Death (Month, Day, Year): SEPT. 30, 1997
3. Time of Death: 11:00 A.M.
4a. Facility Name *(If not institution, give street and number)*: HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 541-28-8056
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 30, 1919
9. Birthplace *(State or Foreign Country)*: NEW YORK, NY

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14724 LOCUSTWOOD LANE
10f. Zip Code: 20905
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: FINANCIAL DIRECTOR
16b. Kind of Business/Industry: PUBLISHING

17. Father's Name *(First, Middle, Last)*: PETER ARVONIO
18. Mother's Name *(First, Middle, Maiden Surname)*: CHARLOTTE PASSARIELLO

19a. Informant's Name/Relationship *(Type, Print)*: STEPHAN SAUNDERS HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14724 LOCUSTWOOD LANE, SILVER SPRING, MD 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GATE OF HEAVEN CEMETERY | Date: 10/6/97
20c. Location - City or Town, State: HAWTHORNE, NY

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: JOSEPH GAWLER'S SONS INC. 5130 WI AVENUE NW WASHINGTON, D.C. 20016

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ACUTE PULMONARY FAILURE	1 DAY
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b.	CHRONIC OBSTRUCTIVE LUNG DISEASE	2+ YRS
Due to (or as a consequence of):		
c.	NON SMALL CELL LUNG CANCER	1 YR
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIAS

ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Linda M Burrell MD
29c. License number: D35996
29d. Data signed *(Month, Day, Year)*: 10-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LINDA M BURRELL, MD 2101 MEDICAL PARK DRIVE #210, SILVER SPRING, MD 20910

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 03 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31149

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Luis F. Salinda

2. Date of Death Month Day Year: September 26, 1997

3. Time of Death: 7:15 AM

4a. Facility Name *(If not institution, give street and number)*: 4720 Norbeck Road

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 230-13-3297

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 5, 1920

9. Birthplace *(State or Foreign Country)*: Philippines

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4720 Norbeck Road

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Country Club

17. Father's Name *(First, Middle, Last)*: Victorio Salinda

18. Mother's Name *(First, Middle, Maiden Surname)*: Carmen Franco

19a. Informant's Name/Relationship *(Type, Print)*: Esperanza M. Salinda/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4720 Norbeck Road, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery | Date: Sept. 30, 1997

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Ronald Faust M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dilated Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel J. Goldberg

29c. License number: D21334

29d. Date signed *(Month, Day, Year)*: September 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel J. Goldberg, M.D. 3801 International Dr., Silver Spring, MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jane L. Sumner

2. Date of Death (Month, Day, Year): September 30, 1997

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-48-7553

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 26, 1909

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: MD

10b. County: Frederick

10c. City, Town or Location: Emmitsburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18 Robindale Drive

10f. Zip Code: 21727

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): J. Stewart

18. Mother's Name (First, Middle, Maiden Surname): Etta S. Hicks

19a. Informant's Name/Relationship (Type, Print): grandchild Wendy J. Sumner-Crummitt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Robindale Drive, Emmitsburg, MD 21727

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: 10/2/97

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Tracy A. Stuver

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Right Parietal Intracerebral Hemmorhage — 1 week

Due to (or as a consequence of):

b. Atrial Fibrillation — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D32171

29d. Date signed (Month, Day, Year): 9/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard L. Gough P.O. Box 328 Walkersville, MD 21793

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31151

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL TAYLOR

2. Date of Death Month Day Year: SEPTEMBER 25 1997

3. Time of Death: 2:40 PM

4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death: CLINTON

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 213-82-1751

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 29 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 5, 1968

9. Birthplace (State or Foreign Country): WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: UPPER MARLBORO

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10704 PHILLIPS DR.

10f. Zip Code: 20772

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STUDENT

16b. Kind of Business/Industry: SCHOOL/COLLEGE

17. Father's Name (First, Middle, Last): WALTER L. TAYLOR

18. Mother's Name (First, Middle, Maiden Surname): CLEMENTINE BENTON

19a. Informant's Name/Relationship (Type, Print): WALTER L. TAYLOR/FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10704 PHILLIPS DR. UPPER MARLBORO, MARYLAND 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY

Date: 10/1/97

20c. Location - City or Town, State: BRENTWOOD, MD.

21. Signature of Funeral Service Licensee: Keith A Savage M1055

22. Name and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia bilateral with effusion — Sept. 97

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Neuromuscular Degenerative Disorder — 11 yrs. ago

Due to (or as a consequence of):

c. Malnutrition

Due to (or as a consequence of):

d. Anemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

History of Respiratory Tract Bleeding

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr. Rosario Fernandez

29c. License number: D19518

29d. Date signed (Month, Day, Year): 9/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROSARIO FERNANDEZ, M.D. 7700 OLD BRANCH AVE. 402 CLINTON, MD. 20735

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: Julia Gardner-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31152

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Charles Larry Tucker
2. Dete of Deeth Month Day Yeer: September 27 1997
3. Time of Death: 12:24 PM
4e. Facility Neme *(If not institution, give street end number)*: Doctors Community Hospital
4b. City, Town, or Location of Deeth: Lanham
4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Number: 578-60-5901
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 50 Yrs.
If Under 1 Yeer: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: 10-07-46
9. Birthplece *(State or Foreign Country)*: Washington DC

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 3408 Halloway North Drive
10f. Zip Code: 20772
10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 2/24/67 2/23/73
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 1+
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Procurement Officer
16b. Kind of Business/Industry: Government

17. Fether's Neme *(First, Middle, Last)*: Charles Farmer
18. Mother's Neme *(First, Middle, Meiden Surname)*: Audrey Tucker

19e. Informent's Neme/Relationship *(Type, Print)*: Sharon Tucker/Wife
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3408 Halloway North Drive, Upper Marlboro MD 20772

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Maryland Veteran's Cem.
Dete: 10/3/97
20c. Location - City or Town, Stete: Cheltenham, Maryland

21. Signeture of Funerel Servica Licensee: ▶ Nancy A. Pecantte
22. Neme end Address of Feciility: J. B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on eech line. — Approximete Interval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)
e. Cerebral Hemmorrhage — 2 days

Due to (or es a consequenca of):
Hypertension — years

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest
b. Due to (or as e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Pert f.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Day Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: ▶ md, mo, phd
29c. License number: D46093
29d. Date signed *(Month, Day, Year)*: September 29, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Radman Mostaghim, MD 7305 Hanover Parkway, Greenbelt, MD 20770

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: SEP 30 1997
32. Registrer's Signeture: John Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHARLES TUCKER

CR

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31153

Amended # 1. Per Doc. P.G.C. 10-1-97 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY R. TODD
2. Date of Death: Month September Day 27 Year 1997
3. Time of Death: 2325 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 027-18-0475
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): JAN. 17, 1920
9. Birthplace (State or Foreign Country): MASSACHUSETTS

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY CO.
10c. City, Town or Location: BOYDS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 22301- PEACHTREE ROAD
10f. Zip Code: 20841
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIRECTOR OF VOLUNTEERS
16b. Kind of Business/Industry: NATIONAL LUTH. HOME

17. Father's Name (First, Middle, Last): LeROY E. BURNHAM
18. Mother's Name (First, Middle, Maiden Surname): IRENE SMITH

19a. Informant's Name/Relationship (Type, Print): MR. JOE TODD- SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9008- GOSHEN VALLEY DR., GAITHERSBURG, MD.

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY-9/29
20c. Location - City or Town, State: ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: ▶ W. M. Hysong
22. Name and Address of Facility: HYSONG CO., INC. 1300- N STREET, NW, WASH., DC

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — Days

Due to (or as a consequence of):
b. Aspiration — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. Swallowing disorder secondary to cerebrovascular accident — Weeks

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation, Gastric ulcer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Alan S. Chanales MD
29c. License number: 29453
29d. Date signed (Month, Day, Year): September 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALAN S. CHANALES 15225 SHADY GROVE RD ROCKVILLE MD 20850

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julia Hudson Randall

DHMH 16 Rev 6/95

97-5511-033
B.K.S
SANDY TOLLIVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SANDY T. TOLLIVER
2. Date of Death (Month, Day, Year): SEPT. 26, 1997
3. Time of Death: 1859 PM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER E.R.
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-64-4199
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov 1, 1947
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: District of Columbia
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3325 Ely Place, S. E., #2
10f. Zip Code: 20019
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: Black

15. Decadent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 (GED) | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Worker
16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): John Henry Tolliver
18. Mother's Name (First, Middle, Maiden Surneme): Stella Mae Gavin

19a. Informant's Name/Relationship (Type, Print): Stella M. Tolliver - Mother
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 3325 Ely Place, S.E.,#2, Washington, D. C. 20019

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): Harmony Memorial Park | Date: 10/2/97
20c. Location - City or Town, Stete: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart III
22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E.,Washington, D.C.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentlelly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? [XX] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient [XX] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year): 9 26 97
28b. Time of Injury: 1700 P M
28c. Injury et Work? 1 [ ] Yes 2 [✓] No
28d. Describe how injury occurred: BROTHER CAR PASSENGER IN CAR STRUCK BY
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADWAY
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): I295 & PORTLAND ST. SW. WASHINGTON DC

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. [XX] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Mecklenburg M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Yeer): SEPT. 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE B. KONOW 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Yeer): OCT 01 1997
32. Registrar's Signature: Julia Thurston Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31155

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IRENEO TONSON
2. Date of Death Month Day Year: SEPTEMBER 27 1997
3. Time of Death: 3:20 PM
4a. Facility Name *(If not institution, give street and number)*: SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-74-4932
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 61 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 15, 1935
9. Birthplace *(State or Foreign Country)*: Philippines

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9905 Allen Gayle Dr.
10f. Zip Code: 20744
10g. Citizen of What Country?: Philippines

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Filipino

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ground Crew
16b. Kind of Business/Industry: TWA Airlines

17. Father's Name *(First, Middle, Last)*: Benedicto Tonson
18. Mother's Name *(First, Middle, Maiden Surname)*: Catalina Perez

19a. Informant's Name/Relationship *(Type, Print)*: Marcelina Z. Tonson/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: 9/30/97
20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: George P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 1 hr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert W. Lundblad MD
29c. License number: D47917
29d. Date signed *(Month, Day, Year)*: 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert W. Lundblad MD, Southern Maryland Hospital Clinton, Md. 20735

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: Julia Henderson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

97-5530-033
CMK
BRADLEY L. TURNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31156

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRADLEY LEWIS TURNER
2. Date of Death (Month, Day, Year): SEPTEMBER 28, 1997
3. Time of Death: 0330AM
4a. Facility Name (If not institution, give street and number): 3221 FLORAL PARK ROAD
4b. City, Town, or Location of Death: FORT WASHINGTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-02-7305
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June19, 1964
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 12702 MacDuff Dr.
10f. Zip Code: 20744
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self-Employed
16b. Kind of Business/Industry: Retail Paint Store

17. Father's Name (First, Middle, Last): Anthony G. Turner
18. Mother's Name (First, Middle, Maiden Surname): Sylvia G. Poland

19a. Informant's Name/Relationship (Type, Print): Anthony G. Turner (Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 235 W. 56th St. #37N, New York, NY 10019

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Memorial Gardens
Date: 10/2/97
20c. Location - City or Town, State: Wilson, North Carolina

21. Signature of Funeral Service Licensee: ▶ Jack P. Kalas III
22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd.,Oxon Hill, MD 20745

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yas 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 9-28-97
28b. Time of Injury: 0138 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Driver inside accident
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3221 Floral Park RD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Aaron Locke MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): SEPTEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. AARON LOCKE, MD, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julie Madison Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(12)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31157

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN ANN THOMPSON

2. Date of Death Month / Day / Year: SEPTEMBER 25, 1997

3. Time of Death: 02:04AM FOUND

4a. Facility Name (If not institution, give street and number): 6012 INWOOD STREET

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 401-86-9437

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): July 31, 1957

9. Birthplace (State or Foreign Country): Ohio

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6012 Inwood Street

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Naver Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Spacify only highest grade completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Donald F. Thompson

18. Mother's Name (First, Middle, Meiden Surneme): Patricia A. Carroll

19a. Informent's Neme/Reletionship (Type, Print): Donald F. Thompson - Father

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3831 St. Andrews Drive, Fairborn, Ohio 45324

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☒ Removal from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Spring Valley Cemetery

Dete: 9/29/97

20c. Location - City or Town, Stata: Spring Valley, Ohio

21. Signature of Funerei Service Licensee: ▶ Nancy J. Thompson

22. Nama and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximate Intervel Between Onset end Daath

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. CANCER OF BREAST WITH METASTASES

Due to (or es e consequence of):

Sequentieily list conditions, if any, laeding to immediate cause. Enter Underlying Causa (Diseese or injury thet initieted events resulting in deeth) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CEREBRAL PALSY

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Plece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, offica building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end manner as steted. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: PME D33954

29d. Dete signed (Month, Day, Year): SEPTEMBER 25, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MARIO F. GOLIA JR MD 3031 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Dey, Year): OCT 01 1997

32. Registar's Signeture: [signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'naturel', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE TOTTEN, III

2. Date of Death Month Day Year: SEPTEMBER 30, 1997

3. Time of Death: 08:13 PM

4a. Facility Name (If not Institution, give street and number): SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death: CLINTON

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-38-8489

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 10, 1934

9. Birthplace (State or Foreign Country): Washington, D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Virginia

10b. County: Fairfax

10c. City, Town or Location: Alexandria

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9377 Mt. Vernon Circle

10f. Zip Code: 22309

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: War Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dentist

16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): George A. Totten, Jr.

18. Mother's Name (First, Middle, Maiden Surname): Emma Milkie

19a. Informant's Name/Relationship (Type, Print): Sandra C. Totten/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as item 10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery

Date: 10/4/97

20c. Location - City or Town, State: Clinton, Md.

21. Signature of Funeral Service Licensee: Geo. P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME

29c. License number: D33954

29d. Date signed (Month, Day, Year): SEPTEMBER 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARIO F. GOLUB JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: Julia Dawson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 225-5620.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97-5497-510
DDG

LAMONT THORTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31159

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: LAMONT A. THORNTON
2. Date of Death Month Day Yeer: SEPTEMBER 26, 1997
3. Time of Death: 3:00 PM
4a. Facility Name *(If not institution, give street and number)*: 3800 GELSTON DRIVE
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth:

Funeral Director

5. Social Security Number: 220-88-7739
6. Sex: 1☒ M 2☐ F — XX
7. Age *(In yrs. last birthday)*: 24 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: JUNE 8,1973
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residenca of Decedant

10a. Stete: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: CAPITAL HEIGHTS
10d. Inside City Limits: 1☒ Yes 2☐ No — X
10e. Street end Number: 6842 JADE COURT
10f. Zip Code: 20743
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorcad — X
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No — XX — Specify:
14. Raca - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; Collega (1-4or 5+):
16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT usa retired)*: LANDSCAPER
16b. Kind of Business/Industry: PRIVATE INDUSTRY

17. Fether's Name *(First, Middle, Last)*: LARRY M. THORNTON
18. Mother's Name *(First, Middle, Maiden Surname)*: PATRICIA BELL

19a. Informant's Name/Ralationship *(Type, Print)*: PATRICIA L. SMOTHERS(MOTHER)
19b. Mailing Addrass *(Straat and Number or Rural Route Number, City or Town, State, Zip Code)*: 6842 JADE COURT, CAPITAL HGTS,MD. 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)* — X
20b. Place of Disposition *(Nama of camatery, crematory or othar placa)*: WOODLAWN MEM. PARK
Date: OCT.2,1997
20c. Locetion - City or Town, Stata: BALTIMORE, MD.

21. Signatura of Funeral Service Licensee: Ralph Williams
22. Name and Address of Facility: RALPH WILLIAMS FUNERAL SERVICE 517 - 11th STREET, SE; WASH., DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not entar the mode of dying, such as cerdiac or raspiratory arrest, shock, or haert failure. List only one cause on each lina. — Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): e. Gunshot Wound to Neck

Due to (or as e consequanca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b.
Due to (or as a consequenca of):
c.
Due to (or as a consequanca of):
d.

Part II. **Othar aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown — X

24a. Was an autopsy performed? 1☒ Yes 2☐ No — X
24b. Were autopsy findings available prior to completion of cause of daath? 1☒ Yes 2☐ No — X

25. Was case rafarred to medical examiner? 1☐ Yes 2☐ No — X

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* — X

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicida 4☒ Homicida — X 5☐ Panding Investigation 6☐ Could not be datarminad

28a. Date of Injury *(Month, Day Year)*: 9-26-97
28b. Time of Injury: 1500 M
28c. Injury at Work? 1☐ Yes 2☒ No — X
28d. Describe how injury occurred: Subject shot
28e. Place of Injury - At home, farm, street, factory, offica building, atc. *(Spacify)*: IN AUTO
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 3800 Gelston Drive

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Phyaician:** To tha bast of my knowledga, daath occurred at the time, data end place, and due to the ceusa(s) and mannar as stated. 2☒ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred et the tima, data and placa, and due to the ceusa(s) and manner stated. — X

29b. Signature and title of certifiar: Jaron Locke MD
29c. License number: O.C.M.E.
29d. Data signed *(Month, Day, Yaar)*: SEPTEMBER 27, 1997

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): JARON LOCKE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrer's Signature: John Dwayne Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(6)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend #4a, 10/3/97, BMW, Montg. Co.
Amend #8, 10/3/97, BMW, Montg. Co.

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 97 31160

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Deeth Month	Day	Year	3. Time of Death
RUTHBELL MEDORA TAYLOR	Sept	26,	1997	1:08am

4e. Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Death
~~Holy Cross Hospital~~ 8446 12th Avenue	Silver Spring	Montgomery

Funeral Director

5. Sociel Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Deys	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (Stete or Foreign Country)
592-20-8887	1☐ M 2☒ F	60 Yrs.					~~Jan. 7, 1957~~ Jan. 7, 1937	Jamaica

Usual Residence of Decedent

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
8446 12th Ave.	20903	Jamaica

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12	2	Nurse Aide	Medical

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surname)
Hezekiah Brown	Marian Vincent

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Cleveland Taylor (Husband)	8446 12th Ave Silver Spring, MD 20903

20e. Method of Disposition	20b. Placa of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven	10/4/97	Silver Spring

21. Signature of Funeral Service Licensee: Wilbur S. Pope Jr.

22. Name and Address of Facility: Pope Funeral Home, 11315 Lockwood Dr. Silver Spring, MD 20904

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel disease or condition resulting in death)	e. Chronic Myelogenous Leukemia	8 years
	Due to (or es a consequence of):	
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest	b.	
	Due to (or as e consequenca of):	
	c.	
	Due to (or es e consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed?	24b. Were autopsy findings evellable prior to completion of cause of deeth?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Deeth (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☑ Residenca 6☐ Other (Specify)

27. Menner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner es steted.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and menner stated.

29b. Signature end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
~~Florent~~, MD	20542	9/26/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)
Joseph Catlett, MD 110 Irving Street NW Washington, DC 20011

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrar's Signature
OCT 03 1997	Yuka Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

BMW

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31161

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Pearl M. Thring

2. Dete of Deeth — Month: September, Dey: 28, Yeer: 1997

3. Time of Deeth: 9:05 AM

4e. Feciity Neme *(If not institution, give street end number)*: Potomac Valley Nursing Home

4b. City, Town, or Location of Deeth: Rockville

4c. County of Deeth: Montgomery

Funeral Director

5. Sociel Security Number: 224-62-5389

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 95 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: July 4, 1902

9. Birthpiece *(Stete or Foreign Country)*: Virginia

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1235 Potomac Valley Road

10f. Zip Code: 20850

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Frank Payne Bell

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Cordelia Clarke

19e. Informent's Name/Reletionship *(Type, Print)*: Elizabeth Thring/daughter

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8708 1st Avenue, #705, Silver Spring, MD 20910

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Lakeside Memorial Park — Dete: October 3, 1997

20c. Location - City or Town, Stete: Winterhaven, Florida

21. Signature of Funerel Service Licensee: Barbara J. McMullen Lawrence M00831

22. Neme end Address of Feciity: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) e.	Pneumonitis	1 week
Due to (or es e consequence of): b.	Cerebrovascular Accident	15 years
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest — Due to (or es e consequence of): c.		
Due to (or es e consequence of): d.		

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated.

29b. Signature end title of certifier: Charles P. Duvall

29c. License number: D0122

29d. Date signed *(Month, Dey, Yeer)*: September 29, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Charles P. Duvall, M.D. 3301 New Mexico Avenue, NW, #348, Washington, DC 20016

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 02 1997

32. Registrer's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31162

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edith W. Thomas

2. Date of Death (Month, Day, Yeer): September 29, 1997

3. Time of Death: 5:00 am

4a. Facility Name (If not institution, give street and number): Mediplex of Montgomery Village

4b. City, Town, or Location of Death: Gaithersburg

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 012-22-1283

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 22, 1923

9. Birthplaca (State or Foreign Country): Pennsylvania

Usual Residanca of Dacadant

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Straat and Number: 8984 Centerway Road

10f. Zip Coda: 20879

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yeer or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: Black

15. Dacadant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

Collega (1-4or 5+):

16a. Dacadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Senior Clerk

16b. Kind of Business/Industry: Government

17. Fathar's Name (First, Middle, Last): Edgar Johnson

18. Mothar's Nama (First, Middle, Maiden Surname): Sara Plummer

19a. Informant's Nama/Ralationship (Type, Print): Eric W. Thomas (Son)

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8984 Centerway Rd. Gaithersburg, MD 20879

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other piece): Parklawn Cemetery

Data: 10-4-97

20c. Location - City or Town, Stata: Rockville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on each lina.

Approximata Intarval Batwaen Onset and Daath

Immadiata Cause (Finel disaasa or condition resulting in daath): e. Congestive Heart Failure — YEARS

Due to (or as a consequanca of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated avants rasulting in daath) Lest:

b. Due to (or as a consaquance of):

c. Dua to (or as a consequence of):

d.

Part II. **Other signifkant conditions** contributing to daath but not resulting in tha undarlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case refarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☒ Nursing Home 5☐ Residanca 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the bast of my knowledge, death occurred at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ Gabriel A Berrebi

29c. License number: 30692

29d. Data signed (Month, Day, Year): 9-30-97

30. Name and address of person who complatad causa of death (Item 23a) (Type, Print): Gabriel A. Berrebi, M.D. 15200 Shady Grove Rd. Suite 305 Rockville, MD 20850

State Registrar

31. Data filad (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: ▶ Jacqueline Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31163

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Achamma M. Thomas
2. Dete of Deeth Month Dey Yeer: September 29, 1997
3. Time of Deeth: 1:40 PM
4e. Feciity Neme *(If not institution, give street and number)*: 11005 Huntover Drive
4b. City, Town, or Location of Death: Rockville
4c. County of Deeth: Montgomery

Funeral Director

5. Social Security Number: 244-70-6589
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 12, 1914
9. Birthplace *(State or Foreign Country)*: Eraviperoor, India

To Be Completed by Funeral Director

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 11005 Huntover Drive
10f. Zip Code: 20852
10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* Indian

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Physician
16b. Kind of Business/Industry: Medicine

17. Fether's Neme *(First, Middle, Last)*: M. O. Mathai
18. Mother's Name *(First, Middle, Maiden Surname)*: Acheyamma Mathai

19e. Informant's Name/Reletionship *(Type, Print)*: George R. Thoma Son
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10624 Kenilworth Avenue, Bethesda, Maryland 20814

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Date: 9-30-97
20c. Location - City or Town, Stete: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Esther L. Villella
22. Name and Address of Feciity: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. Metastatic Breast Cancer — 8 years

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signature end title of certifier: ▶ Trehan
29c. License number: D33224
29d. Dete signed *(Month, Day, Year)*: September 29, 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Ram Trehan, M.D. 50 West Edmonston Drive, Ste. 401, Rockville, Maryland 20852

State Registrar

31. Dete filed *(Month, Day, Year)*: SEP 3 0 1997
32. Registrar's Signeture: ▶ Lia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended # 7, 9/30/97, JW, Mont. Cty.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31164

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
Emma Thelma Towles	9	25	97	8:45 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care Largo	Largo, MD	Prince Georges

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-60-0521	1☐ M 2☒ F	88 ~~87~~ Yrs.					1-28-09	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
		Washington, DC	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
500 21st Street, N.E.	20002	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charlton Wilbur Freeman	Lucy Florence Williams

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Florence T. Rosser (daughter)	914 Booker Drive, Seat Pleasant, MD 20743

20a. Method of Disposition	20b. Pleca of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Harmony Memorial Cemetery	9-30-97	Landover, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Lynne The Guire	McGuire Funeral Service, Inc. 7400 Georgia Avenue, N.W. Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel diseese or condition resulting in death)	a. Metastatic Colon Carcinoma	yrs
	Due to (or as a consequence of):	
Sequentialty list conditions, if eny, leading to immedlate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Lest	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	D32761	9-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard S. Feldman MD 9300 Annapolis rd, Lanham MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
SEP 30 1997	[signature] Linda Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLORIA J. TURNER
2. Date of Death (Month, Day, Year): OCT. 1, 1997
3. Time of Death: 2:15 A
4a. Facility Name (If not institution, give street and number): 3342 Hewitt Ave., Apt. 70
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 213-46-5085
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 3,1946
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3342 Hewitt Ave., Apt. 70
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Adminstrative Assist.
16b. Kind of Business/Industry: Vitro Corp.

17. Father's Name (First, Middle, Last): Joseph Dorsey
16. Mother's Name (First, Middle, Maiden Surname): Martha E. Snowden

19a. Informant's Name/Relationship (Type, Print): Albert D. Turner, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3342 Hewitt Ave., #70, Silver Spring,MD 20906

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Mem. Park
Date: 10/6/97
20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Bruce R. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY INSUFFICIENCY
Due to (or as a consequence of):
b. PROGRESSIVE METASTATIC DISEASE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. NON SMALL CELL LUNG CANCER
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitra Rajagopal, M.D.
29c. License number: D. 42452
29d. Date signed (Month, Day, Year): 10/02/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. CHITRA RAJAGOPAL, M.D. 18111 PRINCE PHILIP DRIVE, SUITE 323 OLNEY, MD 20832

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31166

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Reba B. Tracewell

2. Date of Death (Month, Day, Year): September 30, 1997

3. Time of Death: 6:05 PM

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-10-6443

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 8, 1906

9. Birthplace (State or Foreign Country): Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3304 Saville Lane

10f. Zip Code: 20721

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Candy Maker

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Benjamin F. Back

18. Mother's Name (First, Middle, Maiden Surname): Adabelle Moyer

19a. Informant's Name/Relationship (Type, Print): James H. Bush Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3304 Saville Lane, Bowie, Maryland 20721

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 10-1-97

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: ▶ Eyl Lee L. Villella

22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part i. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Finai diseese or condition resulting in deeth)

a. Cardiovascular Collapse — 3 days

Due to (or es a consequence of):

b. Cerebral Thrombosis

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part ii. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part i.

23b. Did tobacco use contribute to tha cauae of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury M

28c. injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(s) end manner as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶ Gursewa S. Pabla MD

29c. License number: D09850

29d. Date signed (Month, Day, Year): October 1, 1997

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Gursewa S. Pabla, MD 13621 Baltimore Avenue, Laurel, Maryland 20707

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31167

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lula B. White

2. Date of Death (Month, Day, Year): September 24, 1997

3. Time of Death: 10:15PM

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 401-58-2677

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 3, 1944

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5806 Chrisfield Court

10f. Zip Code: 20745

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): U.S. Postal Service

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Jessie Boyd

18. Mother's Name (First, Middle, Maiden Surname): Anna Pearson

19a. Informant's Name/Relationship (Type, Print): Beverly Flowers/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5806 Chrisfield Ct., Oxon Hill, MD 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cemetery

Date: 9/30/97

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Road, N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	4 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Hypertension	20 Years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Diabetes Mellitus

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): ☒ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hilary H. Washington

29c. License number: D32800

29d. Date signed (Month, Day, Year): 9-26-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hilary H. Washington - 11701 Livingston Road, Ft. Washington, MD 20744

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997

32. Registrar's Signature: Julia Theodora Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31168

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles H. Williams, Jr.
2. Date of Death (Month, Day, Year): Sept. 24, 1997
3. Time of Death: 10:50 P.M.
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-52-8580
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/26/38
9. Birthplace (State or Foreign Country): Wash.,D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: P.G.
10c. City, Town or Location: Capitol Hgts.
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 505 Topeka Ave.
10f. Zip Code: 20743
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): 12th
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Body Fender Repairman
16b. Kind of Business/Industry: Auto Body

17. Father's Name (First, Middle, Last): Herman Williams
18. Mother's Name (First, Middle, Maiden Surname): Maureen Jessie

19a. Informant's Name/Relationship (Type, Print): Barbara J. Williams/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10 above

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Mem. Park
Date: 9/30/97
20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: ▶ Larry W. Pratt
22. Name and Address of Facility: H.S.Washington & Sons, Inc. 4925 Burroughs Ave., N.E.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Terminal Pancretic Cancer
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Very Poor Nutritional Status

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Invastigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year): N.A.
28b. Time of Injury: N.A. M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: N.A.
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N.A.
28f. Location (Street and Number or Rural Route Number, City or Town, State): N.A.

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: ▶ S Bahadur
29c. License number: D0052045
29d. Date signed (Month, Day, Year): 9-26-97
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): SARDAR BAHADUR MD - HOLY CROSS HOSP. 1500 FOREST GLEN Rd - SILVER SP. MD. 20910

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 01 1997
32. Registrar's Signature: Julia Theodora Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31169

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Wilderman

2. Date of Death: Month 09 Day 27 Year 97

3. Time of Death: 1725

4a. Facility Name (If not institution, give street and number): 6111 MONTROSE ROAD APT.213

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 098-01-4103

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 22, 1910

9. Birthplace (State or Foreign Country): NEW YORK

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: ROCKVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6111 MONTROSE ROAD APT.213

10f. Zip Code: 20852

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERICAL

16b. Kind of Business/Industry: NEWSPAPER SUPPLY COMPANY

17. Father's Name (First, Middle, Last): ISAAC GARFINKEL

18. Mother's Name (First, Middle, Maiden Surname): ROSE FEINERMAN

19a. Informant's Name/Relationship (Type, Print): MICHAEL WILDERMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1606 TIMBERLINE ROAD, SILVER SPRING, MARYLAND 20904

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BETH EL CEMETERY

Date: 9/30/97

20c. Location - City or Town, State: WESTWOOD, NEW JERSEY

21. Signature of Funeral Service Licensee: Frank A Stasel

22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardiac Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Cardiomyopathy

Due to (or as a consequence of):

c. Valvular heart disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sujata Ambardar MD

29c. License number: D50026

29d. Date signed (Month, Day, Year): 9/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SUJATA AMBARDAR 10215 Fernwood Rd Bethesda MD 20817

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31170

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret S. West

2. Date of Death: Month: Sept. Day: 26 Year: 1997

3. Time of Death: 6:08 P.M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-52-7260

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 16, 1921

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3415 Glenmoor Drive

10f. Zip Code: 20815

10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John N. Swartzell

18. Mother's Name (First, Middle, Maiden Surname): Anna Drury

19a. Informant's Name/Relationship (Type, Print): Harry D. West, III - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4508 Three Pine Lane Virginia Beach, VA 23457

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Mount Comfort Crematory

Date: 9/29/97

20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D.C. 20016

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. small cell bronchogenic carcinoma — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sanford N. Richman M.D.

29c. License number: D11946

29d. Date signed (Month, Day, Year): 9/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richman Sanford, M.D. 10215 Fernwood Rd. #401A, Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31171

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lew Warshof

2. Date of Death Month / Day / Year: September 24 1997

3. Time of Death: 1520

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 093-09-7190

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 15, 1916

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 20109 Torrey Pond Place

10f. Zip Code: 20879

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: Liquor Store

17. Father's Name *(First, Middle, Last)*: Morris Warshafsky

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Kreiselman

19a. Informant's Name/Relationship *(Type, Print)*: Ruth Warshof/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20109 Torrey Pond Pl Gaitherburg, MD 20879

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Judean Mem. Gdns.

Date: 9/26/97

20c. Location - City or Town, State: Olney, MD

21. Signature of Funeral Service Licensee: ▶ Peter R. Ham

22. Name and Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Ischemic Cardiomyopathy — 15 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia — 2 Weeks

Due to (or as a consequence of):

c. Renal Failure — 1 Week

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Prostate Cancer

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Richard Weinstein, MD

29c. License number: D42777

29d. Date signed *(Month, Day, Year)*: September 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard Weinstein 15225 Shady Grove Road Rockville, MD 20850

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31172

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Walter Wyburn Washabaugh
2. Date of Deeth Month / Dey / Yaar: September 25,1997
3. Time of Death: 11:30 AM
4a. Facility Neme *(If not institution, give street end number)*: 5019 Berwyn Road
4b. City, Town, or Location of Deeth: College Park
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 511-05-8360
6. Sex: 1☒ M 2☐ F
7. Aga *(In yrs. lest birthday)*: 84 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: July 20, 1913
9. Birthplece *(Stete or Foreign Country)*: Louisiana

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 5019 Berwyn Road
10f. Zip Code: 20740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armad Forces? 1☒ Yes 2☐ No If Yas, Give Yaer or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest greda compleied)*: Elementery/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion *(Giva kind of work dona during most of working life. DO NOT use retired)*: Automotive Procurement
16b. Kind of Business/Industry: Federal Government

17. Fether's Neme *(First, Middle, Last)*: Dee Washabaugh
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Winifred Markham

19e. Informent's Neme/Relationship *(Type, Print)*: Ivah Norah Washabaugh (wife)
19b. Melling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5019 Berwyn Road College Park,Mary land 20740

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Nema of cemetery, cremetory or other piece)*: Metropolitan Crematory
Dete: 9/29/97
20c. Location - City or Town, State: Alexandria,Virginia

21. Signeture of Funaral Service Licensee: ▶ [signature]
22. Nama and Addrass of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd.,W.,Silver Spring,MD 20901

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the deeth. Do not antar the mode of dying, such es cerdiec or respiretory errest, shock, or heart failura. List only one ceuse on aach lina.

Approximata Intervel Between Onset and Deeth

Immedlete Ceuse (Finel disaasa or condition resulting in deeth): e. Pneumonia

Due to (or es e consequence of):

Sequentiellly list conditions, if eny, leeding to immediata ceusa. Enter Underlying Ceuse (Diseese or injury thet initieted events rasulting in deeth) Lest:
b. Multiple Cerebrovascular Accidents — 2 Years
Due to (or es e consequence of):
c.
Dua to (or es e consequance of):
d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Homa 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Panding investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: 25009
29d. Date signed *(Month, Dey, Yeer)*: September 26, 1997

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Pamela M. Mulshine, M.D. 11251 Lockwood Drive Silver Spring,Maryland 20901

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: SEP 29 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BNW

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31173

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rachel Zacher
2. Date of Death Month: Sept. Day: 30 Year: 1997
3. Time of Death: 1:18pm
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 097-52-4325
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 95 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 26, 1901
9. Birthplace (State or Foreign Country): Lithuania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 5225 Pooks Hill Rd.
10f. Zip Code: 20814
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Lest): Raphael Corbman
18. Mother's Name (First, Middle, Maiden Surname): Hannah Unknown

19a. Informent's Neme/Relationship (Type, Print): Miriam Rosenberg/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 8805 Brierly Rd. Chevy Chase, MD 20815

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Park Cemetery
Date: 10/1/97
20c. Location - City or Town, State: Emerson, N.J.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ARTERIAL Embolization	72hr
Due to (or as a consequence of):	b. ATRIAL Fibrillation	2yrs
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last	c. Congestive Heart Failure	2yrs
Due to (or as a consequence of):	d. Arteriosclerotic Cardiovescular Disease	yrs

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Dfd tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred et the time, date and placa, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, In my opinion, death occurred et the time, dete and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D10272
29d. Date signed (Month, Day, Year): 09-30-97

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Morton W. SHAPIRO, M.D. 5225 Pooks Hill Road Beth, Md,

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 02 1997
32. Registrar's Signature: Julia Davidson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31174

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROCHELLE ABEL

2. Date of Death Month Day Year: OCTOBER 12,97

3. Time of Death: 3 PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 215-40-2440

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT. 18, 1937

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3816 CEDARBROOKE PLACE

10f. Zip Code: 21236

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NONE

16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): CHARLES ABEL

18. Mother's Name (First, Middle, Maiden Surname): BERTHA LUTINS

19a. Informant's Name/Relationship (Type, Print): JOSEPH ANASTASIO (GUARDIAN)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): C/O BARC 7215 YORK RD. BALTO., MD 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON (CHIZUK AMUNO)

Date: 10/14/97

20c. Location - City or Town, State: BALTO., MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. RESPITORY FAILURE — HOURS

Due to (or as a consequence of):

b. PNEMONIA — WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MENTAL RETARDATION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K.S. RAO. M.D.

29c. License number: 043462

29d. Date signed (Month, Day, Year): OCTOBER 12 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S. RAO. M.D. NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD.

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 31175

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALFONSO ABRAHAM			2. DATE OF DEATH (Month, Day, Year): OCTOBER 4, 1997	3. TIME OF DEATH: 725 AM
4. SOCIAL SECURITY NUMBER: 214-44-5523	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05/31/33	8. BIRTHPLACE (State or Foreign Country): Philippines
9a. FACILITY NAME (If not institution, give street and number): 11508 ALCINDA LANE NORTH POTOMAC MD 20878		9b. CITY, TOWN OR LOCATION OF DEATH: NORTH POTOMAC MD		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersberg	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11508 Alcinda Lane		10f. ZIP CODE: 20878	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Loan Officer	16b. KIND OF BUSINESS/INDUSTRY: Bank	
17. FATHER'S NAME (First, Middle, Last): Alfonso Abraham		18. MOTHER'S NAME (First, Middle, Maiden Surname): Florencia Quiogue	
19a. INFORMANT'S NAME (Type/Print): Sara Abraham/wife		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11508 Alcinda Lane	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S. Wade		22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, 655 W. Baltimore St. Baltimore, Maryland 21201	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. END STAGE LUNG DISEASE	SIX MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CORONARY ARTERY DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Philip Jay Schwartz MD	29c. LICENSE NUMBER: D24398	29d. DATE SIGNED (Month, Day, Year): ▶ OCTOBER 5, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PHILIP JAY SCHWARTZ MD 15225 SHADY GROVE ROAD ROCKVILLE, MD 20850		
31. DATE FILED (Month, Day, Year): OCT 16 1997	32. REGISTRAR'S SIGNATURE: Jitha Davidson-Randell	

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31176

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julia F. Anderson

2. Date of Death Month Day Year: OCTOBER 11, 1997

3. Time of Death: 3:10 AM

4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219-28-0328

6. Sex: 1☐ M 2☐ F XX

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10-18-07

9. Birthplace *(State or Foreign Country)*: VA

Usual Residance of Decedant

10a. State: MD.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1711 Baker Street

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th grade; Collaga (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: various trades

17. Father's Name *(First, Middle, Last)*: Richard Thornton

18. Mother's Name *(First, Middle, Maidan Sumama)*: Fannie Terrell

19a. Informant's Name/Relationship *(Type, Print)*: Delores Melton

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda)*: 3940 Penhurst Avenue Baltimore, Maryland 21215

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatery, crematory or othar place)*: Cedar Hill Cemetery

Data: 10-17-97

20c. Location - City or Town, Stata: Md. Anne Arundel Co.

21. Signature of Funaral Service Licensea: ▶ [signature]

22. Nama and Address of Facility: Baltimore, Maryland 21202 WM.C.MArch FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. SEPTIC SHOCK — 1 DAY

Dua to (or as a consaquanca of):

b. ASPIRATION PNEUMONIA — 1 DAY

Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Diseasa or Injury that initiatad avants rasulting in death) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compiation of causa of death? 1☐ Yas 2☒ No

25. Was case referrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or invastigation, in my opinion, daath occurrad at the tima, data and place, and dua to the causa(s) and mannar stated.

29b. Signatura and title of certifiar: ▶ Jogindra P Mehta M.D

29c. Licansa number: D41410

29d. Data signed *(Month, Day, Yaar)*: October 11th, 1997

30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print): JOGINDER P. MEHTA, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 16 1997

32. Registrar's Signatura: Freda Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Anderson, Julia

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rav 6/95

97-4785-510
UNK. 97-185
B.K.S
Vernon Bond

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31177

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vernon Bond

2. Date of Death Month AUG. Day 25, Year 1997

3. Time of Death: 1235 PM

4a. Facility Name *(If not institution, give street and number)*: 3420 EDMONDSON AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 33 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 7, 1964

9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3420 Edmondson Avenue

10f. Zip Code: 21229

10g. Citizen of What Country?: unknown

11. Maritel Status: unknown
1☐ Never Married 2☐ Married
3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown
1☐ Yes 2☐ No
If Yas, Give Year or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
unknown
1☐ Yes 2☐ No *Specify:*

14. Rece - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Sacondary (0-12): unknown
Collega (1-4or 5+): unknown

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: unknown

16b. Kind of Busnass/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown

18. Mother's Name *(First, Middla, Maiden Surname)*: unknown

19a. Informant's Name/Ralationship *(Type, Print)*: unknown

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Mathod of Disposition
1☐ Burial 2☐ Cremation 3☐ Removal from State
4☐ Donation 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, Slete

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, of complications that caused tha daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on aach line.

Approximata Interval Between Onset end Death

Immediate Causa (Final disease or condition resulting in death)
a. Undetermined
Due to (or as a consequance of):

Sequentially list conditions, if any, leading to tmmediata cause. Enter Underlying Causa (Disaase or Injury that tnitiated avants resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?
1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No

25. Was case referred to medical examiner?
☒ Yes 2☐ No

26. Place of Daath *(Check only ona)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home ☒ Residence 6☐ Other *(Specify)*

27. Manner of Death
1☐ Natural
2☐ Accident
3☐ Suicide
4☐ Homicide
5☐ Pending investigation
6☒ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*: Unknown

28b. Time of Injury: Unknown M

28c. Injury at Work? Unknown
1☐ Yes 2☐ No

28d. Describe how injury occurred: Unknown

28e. Placa of Injury - At home, farm, streel, factory, office building, atc. *(Specify)*: Unknown

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*: Unknown

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and placa, and due to the causa(s) and mannar as stated.
☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: AUG. 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 16 1997

32. Registrar's Signatura: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maggie V. Brown

2. Date of Death: Month Oct Day 13 Year 1997

3. Time of Death: 9:05pm

4a. Facility Name (If not institution, give street and number): Evergreen Nursing + Rehab Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-74-1743

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 8, 1998

9. Birthplace (State or Foreign Country): VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: na

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 2525 W. BELVEDERE AVENUE

10f. Zip Code: 21215

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Name (First, Middle, Last): CHARLES NELSON

18. Mother's Name (First, Middle, Maiden Surname): MOLLY MERCER

19a. Informant's Name/Relationship (Type, Print): ALICE CATO- DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4236 TOWANDA AVENUE, BALTIMORE, MD #15

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): EBENEZER CHURCH CEM.

Date: 10-17-97

20c. Location - City or Town, State: MIDLAND, VA

21. Signature of Funeral Service Licensee: ▶ G Ladye Warner

22. Name and Address of Facility: MARCH FH.-4300 WABASH AVENUE

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC RENAL FAILURE — YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Kenneth M. Zonies MD

29c. License number: D20333

29d. Date signed (Month, Day, Year): 10/16/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. ZONIES MD 1538 GREENTREE RD PIKESVILLE MD 21208

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that this certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and used as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth A Bost
2. Date of Death: Month October Day 13 Year 1997
3. Time of Death: 13:25
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-07-2397
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 10, 1914
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Edgemere
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2920 Wells Avenue
10f. Zip Code: 21219
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Expeditor
16b. Kind of Business/Industry: Steel Industry

17. Father's Name (First, Middle, Last): William Bost
18. Mother's Name (First, Middle, Maiden Surname): Vera Adams

19a. Informant's Name/Relationship (Type, Print): Mrs. Sylvia M. Bost / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2920 Wells Avenue Edgemere, Maryland 21219

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. | Date: 10/16/97
20c. Location - City or Town, State: Rossville, Maryland

21. Signature of Funeral Service Licensee: Eugene E. Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Ventricular Tachycardia	Three Months
Due to (or as a consequence of): b.	Myocardial Infarction	Fifteen Years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Coronary Artery Disease	Twenty years or more
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: W.G. Tingley MD
29c. License number: N 9381
29d. Date signed (Month, Day, Year): October 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Whittemore G. Tingley, MD Johns Hopkins Hospital, Tower 110

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Watson-Richards

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31180

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AGAFYA BEREZINA

2. Date of Death (Month, Day, Year): October 13, 1997

3. Time of Death: 5:55 P.M.

4a. Facility Name (If not institution, give street and number): 8609 Woodspring Rd.

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-92-0093

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 18, 1919

9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8609 Woodspring Rd.

10f. Zip Code: 21133

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4or 5+): 4 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Stefan Petrozecky

18. Mother's Name (First, Middle, Maiden Surname): Helen Unknown

19a. Informant's Name/Relationship (Type, Print): Jane Setlonok (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8609 Woodspring Rd. Randallstown, MD 21133

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc.

Date: 10-14-97

20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: John K Ayella

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. C A COLON — 6 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible], MD

29c. License number: D 10246

29d. Date signed (Month, Day, Year): 10/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 23 CROSS KEYS DRIVE, OWINGS MILLS, MD 21117

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31181

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Elva Gertrude BIGALKE
2. Dete of Deeth (Month, Day, Year): OCTOBER 14 1997
3. Time of Deeth: 10:22 PM
4a. Fecility Neme *(If not institution, give street end number)*: SHORE NURSING & REHABILITATION CTR.
4b. City, Town, or Location of Deeth: DENTON
4c. County of Deeth: CAROLINE

Funeral Director

5. Social Security Number: 215-01-2831
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Jan. 21, 1916
9. Birthpleice *(Stete or Foreign Country)*: MD.

Usuel Residence of Decedent

10a. State: MD.
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 25335 Calvert Drive
10f. Zip Code: 21639
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Edeetion *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: factory worker
16b. Kind of Business/Industry: garment industry

17. Fether's Neme *(First, Middle, Last)*: Howard W. Hill Sr.
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Mary Elizabeth Rapp

19a. Informent's Neme/Relationship *(Type, Print)*: Janet E. Fleishman, daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 25335 Calvert Dr., Greensboro, MD. 21639

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Meadowridge Cemetery — Dete: 10/17/97
20c. Location - City or Town, Stete: Elkridge, Md.

21. Signeture of Funerel Service Licensee: ▶ Hauda L Lemmer
22. Neme end Address of Fecility: Witzke Funeral HOmes, Inc,. 1630 Edmondson Ave., Catonsville, Md. 21228

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not entar the mode of dying, such es cerdiec or raspiretory srrest, shock, or heert feilure. List only one ceuse on eech line. — Approximete Intervel Between Onset and Deeth

Immedieta Causa (Finel diseese or condition resulting in deeth):
s. ACUTE CEREBROVASCULAR INSUFFICENCY — acute
Due to (or as a consequence of):
b. Cerebroarteriosclerosis
Sequentieily iist conditions, if eny, leading to immedieta ceuse. Entar Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest
Due to (or es e consequance of):
c.
Due to (or es e consequence of):
d.

Part II. **Other signiticsnt conditions** contributing to death but not resulting in the underlying ceusa given in Part I.: Alzheimers Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes sn eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case refarred to medicel exeminer? 1☐ Yes 2☒ No
26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physicisn:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) snd menner es ststed. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ C J Jensen MD
29c. License number: D14664
29d. Dete signed *(Month, Dey, Yeer)*: 10/15/97

30. Neme and eddress of person who completed ceusa of deeth (Item 23e) (Type, Print): CHRISTIAN JENSEN M.D. P.O. BOX 660 DENTON, MD 21629

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 16 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

ELVA BIGALKE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be given to the funeral director. Within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other trauma, even if the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31182

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte M. Bressler

2. Date of Death — Month: October Day: 8 Year: 1997

3. Time of Death: 11:15 A.M.

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare Hammonds Lane Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220 56 0614

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Aug. 14, 1912

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4723 Pennington Avenue

10f. Zip Code: 21226

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home Maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: (not available) Roeader

18. Mother's Name *(First, Middle, Maiden Surname)*: (Not available)

19a. Informant's Name/Relationship *(Type, Print)*: Jeanette Powell / daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3750 St. Margaret Street Baltimore, Maryland21225

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hilltop Service Corp.

Date: 10/15/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Jerome Gronewoldt

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTRIC CARCINOMA

Due to (or as a consequence of):

b. LIVER METASTASES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PNEUMONIA

PARKINSON

DIABETES MELLITUS, TYPE II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard E Fisher MD

29c. License number: D02519

29d. Date signed *(Month, Day, Year)*: 10-9-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Richard E Fisher 4710 Pennington Ave 21226

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

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Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31183

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katherine S Boude

2. Date of Death Month: October Day: 13 Yaar: 1997

3. Time of Death: 6:30 PM

4a. Facility Name *(If not institution, give street and number)*: Keswick Multi Care Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Numbar: 220-30-3757

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yaar)*: 05/04/18

9. Birthplaca *(Stata or Foreign Country)*: Md.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stata: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 707 Murdoch Rd.

10f. Zip Code: 21212

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12): — College (1-4or 5+): +5

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Teacher

16b. Kind of Business/Industry: Goucher College

17. Fathar's Nama *(First, Middla, Last)*: Philip B. Boude

18. Mother's Neme *(First, Middla, Maidan Surnama)*: Theodora Shaw

19a. Informant's Name/Relationship *(Type, Print)*: Mr. John D. Hermant/cousin

19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 9 Brendan Rd. Toronto, Canada M4G2W9

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: Hilltop Service Corp. Date: 10/15/97

20c. Location - City or Town, Stata: Towson, Md.

21. Signature of Funaral Service Licensee:

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. aspiration pneumonia — 2 days

Due to (or as a consequence of):

b. advanced cerebrovascular disease — 5 yrs

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to complation of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Yaar)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: E. Hunter Wilson MD

29c. Licansa number: D12487

29d. Date signed *(Month, Day, Yaar)*: 10.14.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 16 1997

32. Registrar's Signeture: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician or medical examiner, it should be completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31184

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: Rayford W. Burney

2. Data of Death Month Day Yaar: October 6, 1997

3. Tima of Death: 1:30 PM

4a. Facility Nema *(If not institution, give straet and number)*: 3119 Presbury Street

4b. City, Town, or Location of Daath: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Sacurity Numbar: 240-10-2502

6. Sax: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaer)*: April 8, 1913

9. Birthplaca *(Stata or Foreign Country)*: North Carolina

Usual Rasidance of Dacedant

10a. Stata: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 3119 Presbury Street

10f. Zip Code: 21216

10g. Citizan of What Country?: USA

11. Maritei Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yas, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Reca - Amarican Indian, Black, White, atc. *Specify:* Black

15. Decedant's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 3rd Grade; College (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Maintence Department

16b. Kind of Businass/Industry: Baltimore City Mass Transit Authority

17. Fathar's Nama *(First, Middle, Last)*: Lee Burney

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Charity Bringen

19a. Informant's Name/Ralationship *(Type, Print)*: daughter Sherriell Green

19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 923 Ellicott Driveway Baltimore, Maryland 21216

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cematery, crematory or othar placa)*: MD National Memorial Pk

Data: Oct 11th

20c. Location - City or Town, Stata: Laurel, Maryland

21. Signatura of Funeral Service Licansae: Stephen E. Nutter

22. Nama and Addrass of Facility: Nutter Funeral Homes, Inc 2501 Gwynns Falls Pkwy Baltimore, MD 21216

Physician /Medical Examiner

23a. Part I. Entar the disaase, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach lina.

Approximate Intarval Between Onsat and Daath

Immedieta Causa (Final disaasa or condition rasulting in death)
a. Lung Cancer — 6 months
Due to (or as a consaquence of):
b.
Saquantially list conditions, if any, leading to immadiata cause. Entar Undarlying Ceuse (Disaasa or Injury that initiated avants rasulting in death) Last
Dua to (or as a consequence of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings availabla prior to complation of causa of death? 1 [ ] Yas 2 [X] No

25. Was casa raferrad to medical examiner? 1 [ ] Yas 2 [X] No

26. Placa of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Homa 5 [X] Rasidanca 8 [ ] Other *(Specify)*

27. Mannar of Daath: 1 [X] Naturei 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the tima, data and placa, and due to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and placa, and due to the ceuse(s) and manner statad.

29b. Signatura and titla of cartifier: [signature]

29c. Licansa number: D29071

29d. Data signad *(Month, Day, Yaar)*: 10.8.97

30. Nama and addrass of parson who compiatad causa of daath (Item 23e) (Typa, Print): R. KRISHNAN, MD 821 N. EUTAW ST #305 BALTIMORE MD 21201

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 16 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31185

ITEM: 25 per DR. G-752 10-16-97 eoh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Baby Boy CARRIOA
2. Date of Death Month Day Year: September 30, 1997
3. Time of Death: 9:10 P.M.
4a. Facility Name *(If not Institution, give street and number)*: Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: none
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours / Min.: 35
8. Date of Birth *(Month, Day, Year)*: Sept 30, 1997
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1409 Hadwick Drive
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: none-infant
16b. Kind of Business/Industry: none

17. Father's Name *(First, Middle, Last)*: Jorge Carrioa
18. Mother's Name *(First, Middle, Maiden Surname)*: Dina Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Dina Johnson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1409 Hadwick Drive,Essex, Maryland 21221

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Extreme Prematurity — 35 Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the *time*, date and place, and due to the cause(s) and *manner* as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the *time*, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: mcleodmm
29c. License number: RD 2338
29d. Date signed *(Month, Day, Year)*: September 30 1997

30. Name and address of person who completed cause of death (Item 23e) *(Type, Print)*: Dr. Francine Mcleod 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31186

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELDON W. CLARK
2. Date of Death Month: Oct 09 Day: Year: 1997
3. Time of Death: 0142 Pm
4a. Facility Name (If not institution, give street and number): Church Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 576-01-1609
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 15, 1915
9. Birthplace (State or Foreign Country): Utah

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8108 Bullneck Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1941-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Paint Contractor
16b. Kind of Business/Industry: Home Improvement

17. Father's Name (First, Middle, Last): Brigham Clark
18. Mother's Name (First, Middle, Maiden Surname): Hilma Sorensen

19a. Interment's Name/Relationship (Type, Print): Dennis Clark / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 626 Cedar Hill Drive Allentown, PA 18103

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery
Date: Oct. 13, 1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Charles W. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIOGENIC SHOCK — 24 Hours

Due to (or as a consequence of):
b. CARDIOMYOPATHY — Chronic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. ISCHEMIC HEART DISEASE — Chronic

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Edema

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Bokhari MD
29c. License number: D-26594
29d. Date signed (Month, Day, Year): 10/09/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. BOKHARI M.D. 100 N. BROADWAY BALTIMORE MD 21231

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar: Julie [illegible]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-5884-510
DONALD D. CHANDLER
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31187

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD DUANE CHANDLER
2. Date of Death: Month OCTOBER Day 15 Year 1997
3. Time of Death: 1:00 A
4a. Facility Name (If not institution, give street and number): 2220 BROOKFIELD AVE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 385-14-2437
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-20-24
9. Birthplace (State or Foreign Country): MICH.

Usual Residence of Decedent

10e. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2220 BROOKFIELD AVE
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER
16b. Kind of Business/Industry: TRUCKING

17. Father's Name (First, Middle, Lest): ARTHUR CHANDLER
18. Mother's Name (First, Middle, Maiden Surname): STELLA DAVIS

19a. Informant's Name/Relationship (Type, Print): ROBERT CHANDLER-SON
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2704 REISTERSTOWN RD. BALTO, MD 21215

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): GARRISON FOREST
Date: 10-20-97
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Vernon R. Bailey M00014
22. Name and Address of Facility: Bailey Funeral Service 1727 N. MONROE ST BALTO, md 21217

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 24 hours of death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or if item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part f.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? INSPECTION 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marvin Beckwith
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): OCTOBER 15, 1997

30. Name and address of person who completed cause of death (item 23e) (Type, Print): MARVIN BECKWITH MD 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Yeer): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

4.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31188

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SYLVIA BELLE COLEMAN
2. Date of Death Month / Day / Year: OCTOBER 14, 1997
3. Time of Death: 9:10 AM
4a. Facility Name *(If not institution, give street and number)*: 5222 HILLWELL ROAD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-11-5487
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 13, 1926
9. Birthplace *(State or Foreign Country)*: N. CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 5222 HILLWELL ROAD
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☐ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DIETICIAN
16b. Kind of Business/Industry: MEDICAL

17. Father's Name *(First, Middle, Last)*: LEAMON WEATHINGTON
18. Mother's Name *(First, Middle, Maiden Surname)*: EVA (HARPER)

19a. Informant's Name/Relationship *(Type, Print)*: FRANK R. COLEMAN (HUSBAND)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5222 HILLWELL ROAD BALTIMORE, MD 21229

20a. Method of Disposition: 1☐ Burial 2☑ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CARROLL CREMATION
Date: 10/18/97
20c. Location - City or Town, State: HAMPSTEAD, MARYLAND

21. Signature of Funeral Service Licensee: R Craig Witzke Jr
22. Name and Address of Facility: WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. persistent vegetative state — 1 year
Due to (or as a consequence of):
b. cerebrovascular accident — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. gastro intestinal bleeding
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCVD, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Timothy J. Keay MD
29c. License number: D37458
29d. Date signed *(Month, Day, Year)*: 10/14/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Timothy J. Keay Dept PM 29 S. Paca St. Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "Natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31189

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARENCE A. CENTANNI

2. Date of Death Month: Oct Day: 10 Year: 1997

3. Time of Death: 6:50 AM

4e. Facility Name *(If not institution, give street and number)*: ST AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 108-01-5855

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 14, 1912

9. Birthplace *(State or Foreign Country)*: ITALY

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2XX No

10e. Street and Number: 1663 KIRKWOOD ROAD

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: POSTAL CLERK

16b. Kind of Business/Industry: UNITED STATES POST OFFICE

17. Father's Name *(First, Middle, Last)*: LUIGI CENTANNI

18. Mother's Name *(First, Middle, Maiden Surname)*: ASSUNTA RUSSO

19a. Informant's Name/Relationship *(Type, Print)*: THOMAS CENTANNI (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1663 KIRKWOOD ROAD BALTIMORE MARYLAND 21207

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WOODLAWN CEMETERY

Date: OCT. 14, 1997

20c. Location - City or Town, State: WOODLAWN MARYLAND

21. Signature of Funeral Service Licensee: R. Cox Witzke

22. Name and Address of Facility: WITZKE FUNERAL HOME OF CATONSVILLE, INC. 1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic obstructive Pulmonary disease 10 YEARS

Due to (or as a consequance of): pulmonary fibrosis

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2XX No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2XX No

26. Place of Death *(Check only one)*: Hospital: 1XX Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1XX Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature], M.D.

29c. License number: P 11706

29d. Date signed *(Month, Day, Year)*: OCT 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUAN AKSENTIJEVICH, MD 900 CATON AVE. BALTIMORE

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: CLARENCE A. CENTANNI

10+1

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31190

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nathan E. Childress Sr.

2. Date of Death Month Day Year: October 11, 1997

3. Time of Death: 4:00 PM

4a. Facility Name *(If not institution, give street and number)*: VA MHCS Fort Howard Division

4b. City, Town, or Location of Death: Ft. Howard

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 231-36-6759

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 20,1933

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Somerset

10c. City, Town or Location: Marion

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: Rt. 667

10f. Zip Code: 21838

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean Conflict

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Auto Mechanic

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: Philip A. Childress

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Magdalene Lacks

19a. Informant's Name/Relationship *(Type, Print)*: Nathan Childress Jr. / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3085 Halkberry Lane York, Pennsylvania 17404

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery

Date: 10/15/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gene L. Gonce

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D30528

29d. Date signed *(Month, Day, Year)*: Oct 11th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bala Duggirala, MD 9600 North Point Road Fort Howard, MD 21052

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Known As Nathan Childress

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31191

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Edith Cole

2. Date of Deeth — Month: Sept Dey: 5 Yeer: 97

3. Time of Death: 4:50pm

4a. Facility Name (If not institution, give street end number): UMMS

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-22-2753

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): 05/07/1915

9. Birthplece (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1910 Eutaw Place

10f. Zip Code: 21217

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done dunng most of working life. DO NOT use retired): Cord Operator

16b. Kind of Business/Industry: Western Electric

17. Fether's Neme (First, Middle, Last): Harry Young

18. Mother's Name (First, Middle, Maiden Sumeme): Helen Spriggs

19a. Informent's Neme/Relationship (Type, Print): Charles Cole, Jr.

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5604 Elderon Avenue, Balto., MD 21215

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Remavel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Mt. Calvary Cemetery

Dete: 9/10

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Servica Licensee: ▶ Leroy O Dyett

22. Neme end Address of Feclity: LEROY O. DYETT & SON FUNERAL HOME, P..A. 4600 LIBERTY HEIGHTS AVENUE, BALTO. 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha moda of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onsat and Death

Immediate Ceuse (Final diseese or condition resulting in deeth): e. coronary artery disease — unknown

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☐ No

26. Piece of Deeth (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier: ▶ B. Eule MD

29c. License number: D 43742

29d. Date signed (Month, Dey, Yeer): 10/6/97

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): Brian Euenle, MD UMMS

State Registrar

31. Dete filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randalls

DHMH 16 Rev 6/95

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Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylend Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31192

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELIZABETH CANNING

2. Data of Death Month Day Yaar: OCTOBER 13, 1997

3. Time of Death: 2:20PM

4a. Facility Name (If not institution, giva street and number): GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-48-0014

6. Sax: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 95 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 3/18/02

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Dacedant

10a. Stata: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 941 BEAVERBANK CIRCLE

10f. Zip Coda: 21286

10g. Citizan of What Country: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Year or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - Amarican Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grada complatad): Elamentary/Secondary (0-12): 12th GRADE; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): HOMEMAKER

16b. Kind of Businass/Industry: OWN HOME

17. Father's Nama (First, Middla, Last): JOHN MUIR

18. Mothar's Nama (First, Middla, Maidan Surnama): MARGARET TRAPPE

19a. Informant's Name/Ralationship (Type, Print): PATRICIA TRACEY DAUGHTER

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 941 BEAVERBANK CIRCLE TOWSON, MD 21286

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of cematary, crematory or othar placa): DULANEY VALLEY MEM. GAR.

Data: 10/17/97

20c. Location - City or Town, Stata: COCKEYSVILLE, MD

21. Signature of Funaral Service Licensee: ▶ [signature]

22. Nama and Addrass of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Entar tha disease, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwaen Onsat and Death

Immediata Causa (Final diseasa or condition resulting in daath):

a. Congestive Heart Failure — 1-2 weeks

Due to (or as a consaquance of):

b. Acute Myocardial Infarction — 1-2 weeks

Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last

Due to (or as a consequanca of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compiation of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not ba datarmined

28a. Data of Injury (Month, Day Yaar):

28b. Tima of Injury:

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Specify):

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata):

29a. Cartifiar (Check only one): ☒ **Cartifying Phyaician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: ▶ [signature] Attending MD

29c. Licansa number: D37016

29d. Date signed (Month, Day, Year): October 14, 1997

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): Kenneth M. Greene, MD 7801 York Road, Suite 101 Towson, MD 21204

State Registrar

31. Data filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Mary Canning
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31193

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Un Young CHANG
2. Date of Death (Month, Day, Year): October 4, 1997
3. Time of Death: 10:25 a.m.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-47-8372
6. Sex: [X] 1 M 2 F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): AUG. 15, 1913
9. Birthplace (State or Foreign Country): KOREA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: LARNEY
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3515 NORTHWIND ROAD
10f. Zip Code: 21234
10g. Citizen of What Country? KOREA: KOREA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: KOREAN
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMP.
16b. Kind of Business/Industry: CONSTRUCTION
17. Father's Name (First, Middle, Last): KUNG SOON CHANG
18. Mother's Name (First, Middle, Maiden Surname): LEE
19a. Informant's Name/Relationship (Type, Print): HYUN JOO PARK
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3515 NORTHWIND ROAD LARNEY MARYLAND 21234
20a. Method of Disposition: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL Date: OCT. 6, 1997
20c. Location - City or Town, State: TIMONIUM, MARYLAND
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: EVANS CHAPEL OF CHIMES 2325 YORK ROAD TIMONIUM, MARYLAND 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Hypoxemia	6 minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Pulmonary edema	
Due to (or as a consequence of):		
	c. Pulmonary carcinomatosis	
Due to (or as a consequence of):		
	d. Gastric adenocarcinoma	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: RD 01926
29d. Date signed (Month, Day, Year): October 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. J. Kim 9000 Franklin Square Drive Baltimore, Maryland 21237

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Lilia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31194

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theresa M. DiAngelo
2. Date of Death Month Day Year: October 14, 1997
3. Time of Death: 9:50 PM
4a. Facility Name (If not institution, give street and number): 7310 German Hill Road
4b. City, Town, or Location of Death: Dundalk
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-18-6151
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 16, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7310 German Hill Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 Years; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Domenico Ferraracci
18. Mother's Name (First, Middle, Maiden Surname): Mary Carigano

19a. Informant's Name/Relationship (Type, Print): Husband Mr. Frank J. DiAngelo, Sr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7310 German Hill Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. Date: 10/17/1997
20c. Location - City or Town, State: Rossville, Maryland

21. Signature of Funeral Service Licensee: Chas W. Ruck
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Aspiration pneumonia	3 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Alzheimer's dementia	5 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: non-healing pressure sores, poor nutritional status, immobility

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Kathy Travisano
29c. License number: D52631
29d. Date signed (Month, Day, Year): 10/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathy Travis, JH Geriatrics Center, 5505 Hopkins Bayview Circle, Baltimore, MD 21224

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31195

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOMINIC DEPETRIS Sr.

2. Date of Death: Month OCTOBER Day 14 Year 1997

3. Time of Death: 5:20 AM

4a. Facility Name (If not institution, give street end number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 200-30-0819

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 7, 1940

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3704 LaMoine Rd.

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1963-1965

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Programmer

16b. Kind of Business/Industry: Social Security US Government

17. Father's Name (First, Middle, Last): Nicholas DePetris

18. Mother's Name (First, Middle, Maiden Surname): Gene Crisante

19a. Informant's Name/Relationship (Type, Print): Dominic J. DePetris Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3704 LaMoine Rd. Randallstown, MD 21133

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation, Inc. | Date: 10-18-97

20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funeral Service Licensee: John K Amalfi

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. END STAGE LIVER DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest:

b. CIRRHOSIS LIVER

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: BG 4439128

29d. Date signed (Month, Day, Year): OCTOBER 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS GEORGE, NORTHWEST HOSPITAL CENTER, 9101 OLD COURT ROAD. RANDALLSTOWN MARYLAND 21133

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

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R&P

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31196

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: CHARLES DEAN.
2. Dete of Deeth — Month: OCTOBER Dey: 08 Year: 1997
3. Time of Deeth: 01:29 AM
4e. Fecility Neme *(If not institution, give street end number)*: HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: BALTIMORE CITY

Funeral Director

5. Sociel Security Number: 213 32 5508
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. lest birthday)*: 62 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: June 6, 1935
9. Birthplece *(State or Foreign Country)*: Virginia

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 410 Maude Avenue
10f. Zip Code: 21225
10g. Citizen of Whet Country?: U.S.

11. Merital Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Mail Room
16b. Kind of Business/Industry: Sun Paper

17. Fether's Neme *(First, Middle, Last)*: Earl E. Dean
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Cozie Lee Morris

19e. Informent's Neme/Relationship *(Type, Print)*: James Dean / son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4 West 1st Avenue Baltimore, Maryland 21225

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Dean Family Cemetery
Dete: 10/11/97
20c. Location - City or Town, State: Rockingham Co., Va.

21. Signeture of Funerel Service Licensee: Donna M Bogniewski
22. Neme end Address of Fecility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in death)	a. CARDIAC ARRYTHMIA	30 MIN.
	Due to (or es e consequence of):	
Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest	b. HYPERTENSIVE ENCEPHALOPATHY	6 DAYS
	Due to (or es e consequence of):	
	c. METABOLIC ENCEPHALOPATHY	6 DAYS
	Due to (or es e consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION; DIABETES MELLITUS

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of examination end/or Investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Rubina Ehteham (HOUSE STAFF)
29c. License number: AS 2441614 AZ
29d. Dete signed *(Month, Dey, Yeer)*: OCTOBER 08 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): RUBINA EHTESHAM HARBOR HOSPITAL CENTER 3001 SOUTH HANOVER STREET BALTIMORE, MARYLAND 21225

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 16 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumetic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31197

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CECILE EDELSTEIN

2. Date of Death Month Day Year: September 21, 1997

3. Time of Death: 8:55 PM

4a. Facility Name *(If not institution, give street and number)*: Sinai HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 215-54-4205

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 11, 1909

9. Birthplace *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1190 W. Northern Parkway

10f. Zip Code: 21210

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Jewelry

17. Father's Name *(First, Middle, Last)*: Wolf Klaw

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Schroeder

19a. Informant's Name/Relationship *(Type, Print)*: Warren S. Edelstein/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6218 N. Campbell Avenue, Chicago Illinois60659

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Joseph B. VanSant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

#29c

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Large Cell Lymphoma — unknown

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Non transmural Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dwight C Miller MD

29c. License number: P 11239

29d. Date signed *(Month, Day, Year)*: September 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DWIGHT C. MILLER Sinai Hospital 2401 W. Belvedere Ave.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Jacqueline Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31198

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William ERDMAN
2. Deta of Deeth: Month October Dey 13 Year 1997
3. Time of Deeth: 4:00 P.M.
4a. Facility Neme (If not institution, giva street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Deeth: Rosedale
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 219-20-9437
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): 05/29/1925
9. Birthpleca (Stata or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 11 Danben Court
10f. Zip Code: 21236
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorcad
12. Wes Decedant Evar in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Giva Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired): Construction
16b. Kind of Business/Industry: Construction

17. Fether's Neme (First, Middle, Last): Clarence R. Erdman
18. Mother's Nama (First, Middle, Meiden Surneme): Stella I. Deitz

19a. Informent's Neme/Relationship (Type, Print): Donna Riston
19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 9206 Ramblebrook Road Baltimore, Maryland 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or othar piece): Garden of Faith Cemetery
Dete: 10/17/97
20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Servica Licensee: Marlen J. Dippel Jr
22. Nema and Address of Facility: Dippel Funeral Home Inc. 7110 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23e. Pert1. Entar the diseese, complicetions that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immadieta Causa (Final diseesa or condition resulting in daath)
a. Arteriosclerotic Cardio Renal

Due to (or es e consequence of):
b. Vascular Disease

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest
Due to (or es a consequenca of):
c.

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in tha underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yas 2 [ ] No
24b. Were autopsy findings availeble prior to compiation of ceuse of daath? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [ ] No

26. Piece of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [ ] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be detarmined

28a. Data of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At homa, farm, straat, factory, office building, etc. (Specify)
28f. Location (Straet end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Phyeician: To the best of my knowledga, daath occurred et the time, dete end placa, end due to the cause(s) end manner as stated. 2 [ ] Medical Exeminer: On the basis of examinetion end/or investigetion, in my opinion, daath occurred at tha tima, data and place, end dua to the cause(s) end mennar stated.

29b. Signature and title of certifier: Charles F. O'Donnell MD
29c. License number: D-09353
29d. Date signad (Month, Day, Year): 14 October 97

30. Name end eddrass of person who completed causa of daath (Item 23a) (Type, Print): Charles F. O'Donnell MD - 111 Hamlet Hill Rd - Baltimore MD 21210

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31199

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT ELLIOTT, SR.

2. Date of Death — Month: 10 Day: 13 Year: 97

3. Time of Death: 12 noon

4a. Facility Name *(If not institution, give street and number)*: 2703 RIGGS AVE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-07-1963

6. Sex: 1 [X] M 2 [ ] F

7. Age *(in yrs. last birthday)*: 88 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 4/9/09

9. Birthplace *(State or Foreign Country)*: N. CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2703 RIGGS AVE.

10f. Zip Code: 21216

10g. Citizen of Whet Country?: U.S.

11. Maritel Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowad 4 [ ] Divorced

12. Wes Decedent Evar in U,S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yas, Give Yeer or Detes:

13. Wes Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Amarican Indian, Bleck, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8 — College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DRIVER

16b. Kind of Business/Industry: STEEL

17. Father's Name *(First, Middle, Last)*: JAMES ELLIOTT

18. Mother's Name *(First, Middle, Meiden Sumame)*: LAURA (NOT KNOWN)

19a. Informent's Neme/Reletionship *(Type, Print)*: DOLORES JANIFER-DAUGHTER

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1719 LANDMARK DR.-FOREST HILL, MD 21050

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: MD. NAT'L MEM. PARK — Date: 10/17/97

20c. Location - City or Town, Stete: LAUREL, MD

21. Signature of Funerel Service Licensee: Neroda Hector CFSP

22. Name end Address of Facility: E.L. PHILLIPS 1721-27 N. MONROE ST.-BALTO., MD 21217

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications thet ceused tha daath. Do not enter tha moda of dying, such es cardiac or raspiretory errest, shock, or heert fellure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel disaase or condition resulting in daeth)

a. Hepatocellular Carcinoma. — Jan 97

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

b. Liver failure

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** confributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [X] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)* — Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)* 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signatura and titla of certifiar: M. Didolkar

29c. Licansa number: D 22105

29d. Data signed *(Month, Day, Year)*: 10/15/97

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): M.S. DIDOLKAR MD Sinai Hosp. Baltimore MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached and given to the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31200

Certificate of Death

Reg. No.

Robert Ellison

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert W. Ellison
2. Date of Death (Month, Day, Year): October 19, 1997
3. Time of Death: 4 a.m.
4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-26-9905
6. Sex: 1 ☑ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 7, 1931
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 505 Monroe Circle
10f. Zip Code: 21061
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver/Dispatcher
16b. Kind of Business/Industry: Baltimore Sun

17. Father's Name *(First, Middle, Last)*: Aaron Ringrose Ellison
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Liemcoler

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Smith - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 505 Monroe Circle, Glen Burnie, Md. 21061

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park | Date: 10/13/97
20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiomyopathy, ischemic	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequance of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Yaar)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Reddick-Lane - physician
29c. License number: # 48247
29d. Date signed *(Month, Day, Year)*: October 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cherelle Reddick-Lane, North Arundel Hospital, Glen Burnie MD

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

10

Robert Ellison

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31201

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raechun Farrow

2. Date of Death Month: OCT Day: 6TH Year: 1997

3. Time of Death: 2:13 PM

4a. Facility Name *(If not institution, giva straat and numbar)*: Prince Georges Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Hyattsville

Funeral Director

5. Social Security Number: unknown

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 35 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 28, 1962

9. Birthplace *(State or Foraign Country)*: DC

Usual Residance of Decadant

10a. State: Maryland — 10b. County: Prince Georges — 10c. City, Town or Location: Capital Heights — 10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Straat and Number: 1531 Rollins Avenue — 10f. Zip Coda: 20743 — 10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☒ Navar Married 2☐ Marriad 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? unknown — 1☐ Yas 2☐ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decedant's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): unknown — Collaga (1-4or 5+): unknown

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: unknown

16b. Kind of Business/Industry: unknown

17. Fathar's Nama *(First, Middla, Last)*: unknown

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: unknown

19a. Informant's Name/Raiationship *(Type, Print)*: Thelma Farrow McNally/other

19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1533 Rollins Avenue, Capital Heights, Maryland 20743

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☒ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*

Data

20c. Location - City or Town, Stata

21. Signatura of Funaral Service Licansaa: Ronald S. Wade Director

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwaen Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in death)
a. CARDIO RESPIRATORY FAILURE — 3 HR

Due to (or as a consaquanca of):
b. SEPTIC SHOCK — 2 DAYS

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiatad avants rasulting in daath) Last

Due to (or as a consaquance of):
c. AIDS — 7 YR

Due to (or as a consaquance of):
d. PNEUMONIA — 2 DAYS

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☒ No

25. Was case rafarrad to medical examinar? 1☐ Yas 2☒ No

28. Placa of Death *(Check only ona)*: Hospital 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Yaar)*: NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐ Yas 2☒ No

28d. Describa how injury occurrad: NA

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*: NA

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*: NA

29a. Cartifiar *(Check only one)*: 1☐ **Certifying Phyaician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examinar:** On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: MD

29c. Licansa number: D42019

29d. Data signad *(Month, Day, Year)*: OCT 9TH 1997

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): 4350 VAN DUSEN Rd LAUREL MD 20707

State Registrar

31. Data filad *(Month, Day, Year)*: OCT 16 1997

Julia Bernheim-Gondalla

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: Tha law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31202

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MEYER FINKELSTEIN

2. Dete of Deeth: Month OCT. Dey 14 Yeer 1997

3. Time of Deeth: 8:55 AM

4a. Fecility Neme *(If not institution, give street end number)*: CHERRYWOOD MANOR NURSING HOME

4b. City, Town, or Location of Death: REISTERSTOWN

4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Security Number: 213-05-5410

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: 86 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: MAY 28, 1911

9. Birthplece *(Stete or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10e. Stete: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 524 N. CHARLES ST., APT. 218

10f. Zip Code: 21201

10g. Citizen of Whet Country?: USA

11. Merital Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces?: 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 3

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: OWNER

16b. Kind of Business/Industry: NOVELTY & PARTY GOODS

17. Fether's Neme *(First, Middle, Lest)*: ABRAHAM FINKELSTEIN

18. Mother's Neme *(First, Middle, Meiden Surneme)*: SARAH RIFKA PESKOVITCH

19a. Informent's Neme/Relationship *(Type, Print)*: HARRIET APPEL (DAUG.)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 22506 CHARLESTOWN DR. CALABASES, CA 91302

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: BETH JACOB ANSHE VESHEAR

Dete: 10/15/97

20c. Location - City or Town, Stete: ROSEDALE, MD

21. Signeture of Funerel Service Licensee: [signature]

22. Neme end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Pert I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. Probable Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Coronary Artery Disease

Due to (or as a consequence of):
c. Poor left Ventricle function

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, chronic renal failure dementia, congestive heart failure severe Aortic Stenosis

23b. Did tobacco use contribute to the cause of death?: 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes an autopsy performed?: 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death?: 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical exeminer?: 1 [ ] Yes 2 [✓] No

26. Piece of Death *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work?: 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physicien:** To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD

29c. License number: D28304

29d. Date signed *(Month, Dey, Yeer)*: 10/14/97

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): 750 Main St. Reisterstown MD 21136

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 16 1997

32. Registrer's Signeture: Julia Davidson-Gonzalez

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use by the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31203

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lawrence Paul Furtaw, Sr.

2. Date of Death: Month October, Day 13, Year 1997

3. Time of Death: 7:00 AM

4a. Facility Name (If not institution, give street and number): Heritage Meridian Genesis Eldercare

4b. City, Town, or Location of Death: Dundalk

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-6960

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 10, 1911

9. Birthplace (State or Foreign Country): Massachusetts

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 411 Middle River Road

10f. Zip Code: 21220

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 Years

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic

16b. Kind of Business/Industry: Machine Company

17. Father's Name (First, Middle, Last): Alson Furtaw

18. Mother's Name (First, Middle, Maiden Surname): Julia Deno

19a. Informant's Name/Relationship (Type, Print): Elizabeth A. Miner / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1903 Cape May Road Essex, Maryland 21221

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Pk.

Date: Oct. 16, 1997

20c. Location - City or Town, State: Parkville, Maryland

21. Signature of Funeral Service Licensee: Gregory E Ruck

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Coronary Artery Disease — 2 years

Due to (or as a consequence of): b. Hypertension — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c. Parkinson's Disease — 2 years

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Harjit Singh M.D.

29c. License number: D14160

29d. Date signed (Month, Day, Year): 10/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Juliana Gunderson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31204

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Fisher
2. Date of Death Month / Day / Year: October 9, 1997
3. Time of Death: 16:10
4a. Facility Name *(If not institution, give street and number)*: Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death:

Funeral Director

5. Social Security Number: 215-16-5288
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 73 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11/22/1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 100 MT. DeSales Road
10f. Zip Code: 21229
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MASTER PLUMBER
16b. Kind of Business/Industry: PLUMBING & HEATING BUSINESS

17. Father's Name *(First, Middle, Last)*: JOSEPH FISHER
18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH (DETTMER)

19a. Informant's Name/Relationship *(Type, Print)*: CLARA FISHER (WIFE)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 100 MT. DESALES ROAD BALTIMORE, MD 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD VET- GARRISON FOREST
Date: 10/14/97
20c. Location - City or Town, State: MARYLAND

21. Signature of Funeral Service Licensee: Richard Timmerman
22. Name and Address of Facility: WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE. CATONSVILLE, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0026

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than natural, or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease — 5yrs.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
- Myocardial Infarction
- Hypertension
- chronic lung disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Tabassi Surgical Resident
29c. License number: D46356
29d. Date signed *(Month, Day, Year)*: October 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KHOSROW TABASSI Johns Hopkins Hospital.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31205

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOSEPH T FOWLKES
2. Date of Death Month / Day / Year: OCT 12 1997
3. Time of Death: 5 35 PM
4a. Facility Name *(If not institution, give street and number)*: BON SECOURS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-10-3233
6. Sex: 1 ☑ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5-27-1904
9. Birthplace *(State or Foreign Country)*: VA.

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 1000 GILMOR ST
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 HR | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STEEL WORKER
16b. Kind of Business/Industry: BETH STEEL CORP

17. Father's Name *(First, Middle, Last)*: Joseph FOWLKES SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: Un Known

19a. Informant's Name/Reletionship *(Type, Print)*: MARGARET FOWLKES-WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2339 W. LEXington st. BALTIMORE, MD. 21223

20a. Method of Disposition: 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARbutus CEMETERY | Date: 10/17/97
20c. Location - City or Town, Stete: BALTO. MD

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: 1639 N. Broadway Baltimore, md. 21213 JEFF MILLER P. C. FUNERAL HOME Inc

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. 1 – metastatic Cancer of Stomach — < 1 yr

Due to (or as a consequence of):
b. 2 – extensive metastatic disease Cancer — < 1 yr

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. 3 – metastatic prostatic Cancer — 10 yr.

Due to (or as a consequence of):
d. 4 – bladder tumor — < 2 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: dilated hydronephrosis; Athersclerotic disease

23b. Did tobacco uae contribute to the cauae of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were eutopsy tindings avaliable prior fo compietion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] physician
29c. License number: D29769
29d. Date signed *(Month, Day, Year)*: 10/17/97

30. Name end eddress of peteon who completed ceuse of death (Item 23e) (Type, Print): marcelino D. Alboverne MD 516 N. Rolling Rd Balto Md

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31206

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion W. Frissel

2. Date of Death (Month, Day, Year): October 12, 1997

3. Time of Death: 4:15 PM

4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218 12 3635

6. Sex: 1 ☑ M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 2, 1923

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 4459 Norfen Rd.

10f. Zip Code: 21227

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mill Wright

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Frederick Frissel

18. Mother's Name (First, Middle, Maiden Surname): Anna Miller

19a. Informant's Name/Relationship (Type, Print): Sandra Dinel / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4459 Norfen Rd., Baltimore, MD 21227

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory

Date: 10/15/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann

22. Name and Address of Facility: CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ADENOCARCINOMA OF THE ESOPHAGUS — 3 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

GASTRIC TUBE, MUSCLE WASTING

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Perry L Colvin MD

29c. License number: D32548

29d. Date signed (Month, Day, Year): October 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PERRY L. COLVIN MD Baltimore VA Medical Center 10 N. Greene Street, Baltimore

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31207

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kenneth G. Gaskill
2. Date of Death Month: 10 Day: 11 Year: 97
3. Time of Death: 6:15 AM
4a. Facility Name *(If not institution, give street and number)*: 2403 Bridge Hampton Dr. Apt. D.
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 215-80-4669
6. Sex: 1☐M 2☐F XX
7. Age *(In yrs. last birthday)*: 34 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09-22-63
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: Md.
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2403 Bridgehampton Drive Apt."D"
10f. Zip Code: 21234
10g. Citizen of What Country?: USA
11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced XX
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th Grade — College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disabled
16b. Kind of Business/Industry: UnEmployed
17. Father's Name *(First, Middle, Last)*: William J. Gaskill
18. Mother's Name *(First, Middle, Maiden Surname)*: Barbara Boyd
19a. Informant's Name/Relationship *(Type, Print)*: Barbara Gaskill
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2403 Bridgehampton Drive Baltimore, Maryland 21234
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Voshell Mem. Gardens
Date: 10-17-97
20c. Location - City or Town, State: Dundalk, Md.
21. Signature of Funeral Service Licensee: James Cole
22. Name and Address of Facility: March F. H. EAST 1101 E. North Ave Baltimore, Maryland 21202

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CARDIOPULMONARY ARREST

Due to (or as a consequence of):
b. END STAGE RENAL DISEASE — 1 YEAR.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. THROMBOSIS OF SUPERIOR VENA CAVA — 2 WEEKS

Due to (or as a consequence of):
d. SEVERE MEDICAL NON COMPLIANCE —

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES MELLITUS
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☑Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☑No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elias Ghandour MD
29c. License number: D35706
29d. Date signed *(Month, Day, Year)*: 10/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elias C. Ghandour, MD 5601 Loch Raven Blvd., Baltimore, MD 21239

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31208

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bruce W. Grams

2. Date of Death Month Dey Year: October 13, 1997

3. Time of Death: 7:30 p.m.

4a. Facility Name *(If not institution, give street end number)*: 3007 Abell Avenue

4b. City, Town, or Location of Daath: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-42-9784

6. Sax: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthdey)*: 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: May 1, 1940

9. Birthplace *(Stete or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3007 Abell Avenue

10f. Zip Code: 21218

10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Never Marriad 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Datas: 1963-65

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Edcetion *(Specify only highast grede completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4 +

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Congressional Aide

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Lest)*: William R. Grams

18. Mother's Nama *(First, Middle, Maiden Surnema)*: Naomi Hogan

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Betty Moore/Personal Representative

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3007 Abell Avenue Baltimore, Maryland 21218

20e. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or othar piece)*: Memory's Gardens

Date: 10/18/97

20c. Location - City or Town, State: Schenectady, New York

21. Signature of Funeral Service Licensee: Mark T. Zavoyna

22. Name and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the disease, or complicetions that ceused tha death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or haart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final diseasa or condition resulting in death): a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examinar? 1 [X] Yas 2 [ ] No

26. Piece of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Othar *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: Dorothy Snow

29c. Licansa number: D24149

29d. Date signed *(Month, Day, Year)*: 10/14/97

30. Name and address of persan who completed cause of death (Item 23e) (Type, Print): Dorothy Snow, M.D., 10 N. Greene Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as mortuarial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31209

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE GORDON

2. Date of Death Month / Day / Year: OCTOBER 13 1997

3. Time of Death: 955 AM

4a. Facility Name *(If not institution, give street and number)*: Howard county General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 269-28-4998

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5/12/1919

9. Birthplace *(State or Foreign Country)*: Hungary

Usual Residence of Decedent

10a. State: MD.

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 6336 Cedar Lane, Apt. 363

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: white

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Andor Fridges

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth AKos

19a. Informant's Name/Relationship *(Type, Print)*: Mary Ann Ottinger, daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6604 Woodstream Dr., Seabrook, Md. 20706

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Carroll Cremation, Inc.

Date: 10/15/97

20c. Location - City or Town, State: Hampstead, MD.

21. Signature of Funeral Service Licensee: Linda L Lemmer

22. Name and Address of Facility: Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, MD. 21045

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. BRAINSTEM INFARCTION — 24 HOURS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

FEVER

SMALL BOWEL OBSTRUCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Scott Maurer MD

29c. License number: D29909

29d. Date signed *(Month, Day, Year)*: OCTOBER 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT MAURER MD 9501 OLD ANNAPOLIS RD ELLICOTT CITY MD 21042

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature

FAXED 10-13-97

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be distributed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than natural, or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31210

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adamandios Gafos

2. Date of Death (Month, Day, Year): Oct. 12, 1997

3. Time of Death: 2:00 P.M.

4a. Facility Name (If not institution, give street and number): 11730 Mayfair Field Drive

4b. City, Town, or Location of Death: Timonium

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-42-4922

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 3, 1940

9. Birthplace (State or Foreign Country): Chios, Greece

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Timonium

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11730 Mayfair Field Drive

10f. Zip Code: 21093

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Head of Submarine Silencing Improvement

16b. Kind of Business/Industry: Naval Research and Development

17. Father's Name (First, Middle, Last): George Adamandios Gafos

18. Mother's Name (First, Middle, Maiden Surname): Eugenia Georgandis

19a. Informant's Name/Relationship (Type, Print): Jo Marie Gafos - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11730 Mayfair Field Dr. Timonium, Maryland 21093

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Greek Orthodox Cemetery

Date: 10/15/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Michael J. Ruck Jr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. MULTIPLE MYELOMA — 3½ YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Eric J. Seifter MD

29c. License number: D29373

29d. Date signed (Month, Day, Year): 10/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC J. SEIFTER 10755 FALLS RD, SUITE 200 LUTHERVILLE, MD 21093

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

Registrar's Signature: Julia Davidson-Ramsdell

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

30

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31211

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jerry Griffiths

2. Date of Death Month Day Year: OCTOBER 14, 1997

3. Time of Death: 12:27 a

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: N/A

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 9, 1949

9. Birthplace (State or Foreign Country): BERMUDA

Usual Residence of Decedent

10a. State: BERMUDA

10b. County: N/A

10c. City, Town or Location: DEVONSHIRE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1 Christopher's Close

10f. Zip Code: FL 01

10g. Citizen of What Country?: BERMUDA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUBSTANCE Abuse Counseler

16b. Kind of Business/Industry: Charity

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): Shirley Griffiths

19a. Informant's Name/Relationship (Type, Print): Doret E. GRIFFITHS - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box F.L. #202 Smith's FL BX

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 10/16/97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Charles L. Jamison

22. Name and Address of Facility: Charlton Funeral Home 2007 Eastern Avenue Balto. Md. 21231

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Anoxic Brain Injury — 9 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Orthotopic Heart Transplant

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: MD, PGY-1

29c. License number: RES-000

29d. Date signed (Month, Day, Year): October 14 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Philip Seo, 110 Tabes I, Johns Hopkins Hospital, Baltimore Maryland.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31212

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert J. Hand

2. Date of Death: Month OCTOBER Day 6 Year 1997

3. Time of Death: 2245

4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HEALTHCARE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 01 2878

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 2, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3551 Benzinger Road

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: W.W. II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chauffeur

16b. Kind of Business/Industry: Oil Company

17. Father's Name *(First, Middle, Last)*: Edward A. Hand

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth E. Lane

19a. Informant's Name/Relationship *(Type, Print)*: Edward Hand / brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8445 Main Avenue Riviera Beach, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Md. State Veteran Cem.

Date: 10/9/97

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: Richard E. Davis

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. PNEUMONIA — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE, CEREBROVASCULAR DISEASE, ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D0052102

29d. Date signed *(Month, Day, Year)*: OCTOBER 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): NORBERTO CALZADA, M.D. 900 CATON AVE BALTIMORE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julie Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME: HAND, ROBERT JAMES

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31213

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Genevieve I. Helinski

2. Dete of Deeth — Month: October; Dey: 9; Yeer: 1997

3. Time of Death: 4:15 P.M.

4e. Facility Neme *(If not institution, give street and number)*: Genesis Eldercare Hammonds Lane Center

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 18 7234

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 87 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Jan 1, 1910

9. Birthpiece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: Genesis Eldercare 613 Hammonds Lane

10f. Zip Code: 21225

10g. Citizen of Whet Country?: U.S.

11. Meritei Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8th; College (1-4or 5+):

16e. Decedent's Usuei Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Owner - Operator

16b. Kind of Business/Industry: Gas Station

17. Fether's Neme *(First, Middle, Last)*: Joseph Idzik

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary Ann Cebula

19a. Informent's Neme/Reietionship *(Type, Print)*: Dolores Helinski

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 415 Holy Cross Road Baltimore, Maryland 21225

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removei from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: St. Stanislaus Cemetery

Dete: 10/13/97

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signeture of Funerel Service Licensee: ▶ [signature]

22. Neme end Address of Feciility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finei diseese or condition resulting in deeth):
e. Congestive Heart Failure — 3 Days
Due to (or as e consequence of):
b. Coronary Artery Disease — 2 Year

Sequentieily list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed?: 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medicai exeminer?: 1☐ Yes 2☒ No

28. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturai 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 8☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work?: 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Physician MD Attending Doctor

29c. License number: D21684

29d. Dete signed *(Month, Dey, Yeer)*: 10.10.97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): CV CYRIAC M.D, 8109 RIECKS COURT, PASADENA, MD 21122

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 16 1997

32. Registrer's Signeture: ▶ Judith Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be escorted within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31214

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIE L. JAMES

2. Date of Death: Month OCT. Day 4 Year 1997

3. Time of Death: 9:45 AM

4a. Facility Name (If not Institution, give street and number): FOREST HAVEN NURSING HOME

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 578-16-2029

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 6, 1913

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 315 Ingleside Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimroe, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tasneem Lakhani

29c. License number: D28595

29d. Date signed (Month, Day, Year): 10/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE, BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31215

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY JACKSON

2. Date of Death Month Day Year: OCTOBER 15 97

3. Time of Death: 05 07 AM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 205-05-7403

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 102 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 13, 1895

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Randallstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3810 Byxbee Rd.

10f. Zip Code: 21133

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW1

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4or 5+): 1 year

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpentry Teacher

16b. Kind of Business/Industry: Philadelphia Trade Schools

17. Father's Name (First, Middle, Last): Harry Grant Jackson

18. Mother's Name (First, Middle, Maiden Surname): Margaret Jane South

19a. Informant's Name/Relationship (Type, Print): Jean Dearden (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3810 Byxbee Rd. Randallstown, MD 21133

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chelten Hills Cemetery

Date: 10-21

20c. Location - City or Town, State: Philadelphia, PA

21. Signature of Funeral Service Licensee: John K Ayd

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS

Due to (or as a consequence of): b. DECUBITUS ULCERS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE, MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Ravi MD

29c. License number: D37333

29d. Date signed (Month, Day, Year): OCTOBER 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. RAVI MD, NHC, BALTO. MD 21133

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Jackie Davidson-Randall

DHMH 16 Rev 6/95

7+1

7+1RA

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31216

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK L. KEENE
2. Date of Death Month Day Year: OCTOBER 12 1997
3. Time of Death: 12:05PM
4a. Facility Name (If not institution, give street and number): Liberty Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-10-6189
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 2-28-1916
9. Birthplace (State or Foreign Country): Md

Usual Residance of Decedent

10a. State: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3800 W. Belvedere Avenue
10f. Zip Code: 21215
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American indian, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+): NA
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Designer
16b. Kind of Business/Industry: Interior Decorator

17. Father's Name (First, Middle, Last): Charles Keene
18. Mother's Name (First, Middle, Meiden Surname): Hattie Holland

19a. Informant's Name/Reiationship (Type, Print): Lulervert Keene - wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3800 W. Belvedere Avenue Apt 304 Balto, Md 21215
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cemetory or other place): Garrison Forest Vet
Date: 10-16-97
20c. Location - City or Town, State: Owings Mills, Md
21. Signature of Funeral Service Licensee: Gladys Warner
22. Name and Address of Facility: March F.H. West 3300 Wabash Avenue Balto, Md 21215

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediete Ceuse (Final disaasa or condition resulting in death) a.	POSSIBLE MYOCARDIAL INFARCTION	45 YRS
Due to (or as a consequence of): b.	ARTERIOSCLEROTIC HEART DISEASE	UNKNOWN
Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that Initiated events resulting in death) Last — Due to (or as a consequence of): c.	DEMENTIA	
Dua to (or as a consequence of): d.	DEHYDRATION	2 DAYS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION
PERIPHERAL VASCULAR DISEASE
S/P PERCUTANEOUS GASTOSTOMY

23b. Did tobacco uae contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Were autopsy findings avaitiable prior to compiation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Piece of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not ba determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifiar: Anil Uberoi
29c. License number: D26748
29d. Date signed (Month, Dey, Year): 10/12/1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): ANIL UBEROI MD, LIBERTY MEDICAL CENRE 2600 LIBERTY HGTS AVE.

State Registrar

31. Date filed (Month, Dey, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31217

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William C. Klender

2. Date of Death (Month, Day, Year): Oct. 12, 1997

3. Time of Death: 2:00 P.M.

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-14-8505

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 1, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5726 Franklin Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance / Mechanic

16b. Kind of Business/Industry: Harbison-Walker

17. Father's Name (First, Middle, Last): William Augustus Klender

18. Mother's Name (First, Middle, Maiden Surname): Mildred Anna Walter

19a. Informant's Name/Relationship (Type, Print): F. Ruth Klender (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5726 Franklin Avenue Balto., MD. 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Cedar Hill Cemetery

Date: 10/16/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Daniel A. Taylor

22. Name and Address of Facility: McCully-Polyniak Funeral Homes, 237 E. Patapsco Ave. Balto., MD. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Ischemic Heart Disease	24 hrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Non Insulin Dependent Diabetes Mellitus	10 yrs
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

Prior Lymphoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan Neal Dennis MD

29c. License number: D30555

29d. Date signed (Month, Day, Year): October 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Alan Neal Dennis MD 501 E. Fort Avenue, Balto MD 21230

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randolph

DHMH 16 Rev 6/95

6 + UA

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES KENDRICK
2. Date of Death (Month, Day, Year): October 10, 1997
3. Time of Death: 12:03 PM
4a. Facility Name (If not institution, give street and number): BRECC Nursing Home 3900 Loch Raven
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 223-07-0707
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/14/1911
9. Birthplace (State or Foreign Country): S. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1809 N. FULTON AVENUE
10f. Zip Code: 21217
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 7/23/42 - 11/27/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6th | College (1-4or 5+):
16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): Railman
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Eugene Kendrick
18. Mother's Name (First, Middle, Maiden Surname): Annie Parker

19a. Informent's Name/Raiationship (Type, Print): Gertrude Ledbetter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 4116 Oakford Avenue, Baltimore, MD 21215

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, cramatory or other place): Garrison Forest Vet. Cem. | Date: 10/15
20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Servica Licensee: LeroyO Dyett
22. Name end Address of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset end Death

Immediata Causa (Final disease or condition resulting in death)
e. Metastatic prostate carcinoma — 5years

Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or es e consequence of):
c.
Due to (or as e consequenca of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part i.
Gastrointestinal bleeding, Hematuria, Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarminad
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, streat, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To tha best of my knowladga, death occurrad at the time, data and place, and due to the causa(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the causa(s) and manner steted.
29b. Signature and title of cartifier: Perry Colvin
29c. Licensa number: D32548
29d. Date signed (Month, Day, Year): October 10, 1997
30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): PERRY L. COLVIN, MD — Baltimore VA Medical Center 10 N. Greene Street, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

7

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM:24a per DR. G-752 10-16-97 eph

Certificate of Death

Reg. No. 97 31219

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy A. Kerfoot

2. Date of Death: Month: September Day: 28 Year: 1997

3. Time of Death: 6:30PM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-20-8750

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months: Days:

If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): Jan. 17, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 715 Deepdene Road

10f. Zip Code: 21210

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): unknown

College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): William Tydings

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Tydings

19a. Interment's Name/Relationship (Type, Print): William Kerfoot

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 715 Deepdene Road, Baltimore, Maryland 21210

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Joseph B. Van Sant

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 4 hours

Due to (or as a consequence of):

b. Coronary Artery Disease — 30 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Dorothy A. Kerfoot

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD PhD, Resident

29c. License number: AT 2438946 C12

29d. Date signed (Month, Day, Year): September 28 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark D. Phillips MD PhD 29 S. Paca St, Lower Level, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31220

Certificate of Death

Reg. No.

DR. EGON LEFFMAN

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Egon Leffman	October 9 97	1:55AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Center	Towson	Baltimore

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
114-03-6273	1☒ M 2☐ F	92 Yrs.			Sept. 27, 1905	Germany

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore City	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6920 Donachie Road	21239	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Chirapractor	Medical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rudolph Leffman	Gisela Guens

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sidonie Leffman/wife	6920 Donachie Road, Baltimore, Maryland 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatoma — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	None	M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
A. Anthony Riley, MD	D5205	October 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley GBMC 6201 N. Charles St. Balto. Md 21204

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 1997	Joe Davidson-Randall

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31221

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard J. Lance, Jr.

2. Date of Death (Month, Day, Year): October 13 1997

3. Time of Death: 5:20 pm.

4a. Facility Name *(If not Institution, give street and number)*: 1215 Glenhaven Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-40-2609

6. Sex: 1☐ M 2☐ F — XX

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-28-44

9. Birthplace *(State or Foreign Country)*: Md.

Usual Residence of Decedent

10a. State: Md.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1215 Glenhaven Road

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+): 1yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Salvation Army

17. Father's Name *(First, Middle, Last)*: Richard Lance, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary C. Jones

19a. Informant's Name/Relationship *(Type, Print)*: Marie Jones

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1215 Glenhaven Road Baltimore, Maryland 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Mem. Pk. cem.

Date: 10-17-97

20c. Location - City or Town, State: Randallstown, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure — minute

Due to (or as a consequence of):

b. metastatic lung cancer — 4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D44944

29d. Date signed *(Month, Day, Year)*: October 13th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STANLEY Walter, Union Memorial Hospital, Baltimore MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: [signature] Juliet Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be electronically filed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760

Richard Lance

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31222

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES W. LINTON, JR.
2. Date of Death Month / Day / Year: OCTOBER - 15 - 1997
3. Time of Death: 1:35 PM
4a. Facility Name *(If not institution, give street and number)*: BON SECOUR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-22-7236
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 3 1927
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1641 Wilkens Ave.
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver
16b. Kind of Business/Industry: Maryland Chemical Corp.

17. Father's Name *(First, Middle, Last)*: James William Linton Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Henrietta Marquerite Metzler

19a. Informant's Name/Relationship *(Type, Print)*: James W. Linton III (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1641 Wilkens Ave. Baltimore, Md. 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Memorial Pk. — Date: Oct. 18 1997
20c. Location - City or Town, Steta: Elkridge, Md.

21. Signeture of Funeral Service Licensee: ▶ Christina L. Kopcyk
22. Name and Address of Facility: McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Causa (Final disease or condition resulting in death) a.	Hypoxic Respiratory Faulure	Sine 9/9/97
Due to (or as a consequence of): b.	Pneumonia	1 month
Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Congestive Heart Faulure	years
Due to (or as a consequence of): d.	Chronic Obstructive Pulmonary Disease	4 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumothorax

Sepsis

Liver Faulure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Ware autopsy findings available prior to complation of ceuse of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to madical examiner? 1 [ ] Yas 2 [✓] No

26. Place of Daath *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be datermined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 [✓] **Certifying Phyalcian**: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ M Vasanthakumar
29c. License number: D42510
29d. Date signed *(Month, Day, Year)*: Octoba 15th 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): M. VASANTHAKUMAR, 821 N. EUTAW ST # 407 MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "Natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31223

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NICHOLAS LAPETINA
2. Date of Death (Month, Day, Year): October 14, 1997
3. Time of Death: 10:00 p.m.
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-03-4999
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 16, 1910
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 89 Wise Ave.
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 Years | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Ship Yard

17. Father's Name (First, Middle, Last): Antonio Lapentina
18. Mother's Name (First, Middle, Maiden Surname): Anna Cuzzi

19a. Informant's Name/Relationship (Type, Print): Mrs. Marie A. Lapetina/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 89 Wise Ave. Dundalk, Maryland 21222

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery | Date: 10/17/1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Charles Fisher
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Chronic Pulmonary disease.
Due to (or as a consequence of):
b. Pulmonary fibrosis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gout Arthritis

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☒ Other (Specify) Hospice

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edwards MD
29c. License number: D44128
29d. Date signed (Month, Day, Year): 10/15/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. PENELOPE EDWARDS 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kevin Lynch
2. Data of Death Month Day Yaar: October 12, 1997
3. Tima of Deeth: 10:28 AM
4a. Facility Nama (If not institution, give street end number): St. Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 097-09-4964
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): Aug. 24, 1912
9. Birthplace (Stete or Foreign Country): Ireland

Usual Rasidanca of Dacedant

10a. State: Maryland
10b. County: Baltimore Co.
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 406 Rockfleet Road Apt.#103
10f. Zip Coda: 21093-7564
10g. Citizan of Whet Country?: United States

11. Maritai Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Dacedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:
13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elamantary/Secondary (0-12): 12 — Collega (1-4or 5+): 04
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Quality Control Engineer
16b. Kind of Businass/Industry: Westinghouse

17. Father's Nama (First, Middle, Last): Hugh Lynch
18. Mothar's Nama (First, Middle, Maiden Surneme): Margaret Reilly

19a. Intormant's Name/Reletionship (Type, Print): Mrs. Mary Pat (nee Forquer) Lynch (Wife)
19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 406 Rockfleet Road Apt.#103 Timonium, Md. 21093-7564

20a. Mathod of Disposition: 1☒ Buriel 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place ot Disposition (Neme of cemetery, cremetory or other piece): St. John's Church Cem.
Data: 10/15/97
20c. Location - City or Town, State: Hydes, Maryland

21. Signature of Funaral Service Licensee: Jeffrey L. Gair — ▶ Jeffrey L. Gair
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications that causad tha daath. Do not anter the moda ot dying, such as cardiac or raspiratory arrast, shock, or haart tailure. List only ona cause on aach lina.

Approximeta Interval Batween Onset and Death

Immediate Causa (Final disaasa or condition rasulting in daath)
a. Intra cranial hemmorhage — 2 hours
Dua to (or as a consequence of):
b. Hypertension — 5 years
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Diseese or Injury thet initiatad avants rasulting in daath) Last
Dua to (or as a consequance of):
c. oral anticoagulatam — 5 years
Dua to (or as a consaquence of):
d. atrial fibrillation — 5 years

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy tindings available prior to completion ot causa ot death? 1☐ Yas 2☐ No

25. Was case ratarrad to madical examinar? 1☐ Yas 2☐ No
26. Placa ot Daath (Check only one): Hospital: 1☐ Inpatiant 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined
28a. Data ot Injury (Month, Dey Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At home, farm, straat, tactory, office building, atc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To the best ot my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On the basis ot examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and mannar stated.
29b. Signatura and title of certifier: ▶ MD
29c. License number: D26587
29d. Date signed (Month, Day, Year): 10/13/97
30. Neme and address of person who completed cause ot death (Item 23e) (Type, Print): ERIC S. TONER MD 7402 York Rd TOWSON MD 21212

State Registrar

31. Data filed (Month, Dey, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use in obtaining burial-transit

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31225

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bella Lesowitz
2. Dete of Deeth — Month: 10 Dey: 12 Year: 97
3. Time of Death: 10:52 AM
4e. Feciility Neme *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Deeth: Silver Spring
4c. County of Deeth: Montgomery

Funeral Director

5. Socisl Security Number: 085-07-8232
6. Sex: 1☐M 2☒F
7. Age *(In yrs. lest birthdey)*: 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: July 13, 1918
9. Birthplece *(State or Foreign Country)*: New York

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 2921 Chapel View Drive
10f. Zip Code: 20904
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 Years — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Secretarial
17. Fether's Neme *(First, Middle, Last)*: Samuel Kaplan
18. Mother's Name *(First, Middle, Meiden Surneme)*: Gussie Sussman
19a. Informent's Name/Relationship *(Type, Print)*: Timothy Bogen, Son-In-Law
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 906 Irving Avenue, Westfield, New Jersey 07090
20e. Method of Disposition: ☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Mount Lebanon Cemetery — Dete: 10/13/1997
20c. Location - City or Town, Stete: Adelphi, Maryland
21. Signature of Funeral Service Licensee: Donald C. Stottlemyer
22. Neme and Address of Feciility: STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Multiple Myeloma — 1 mo
Due to (or es a consequenca of):
Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☑No

26. Piece of Death *(Check only one)*: Hospitel: 1☑Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐**Medicel Exeminer:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Frederick G Barr MD
29c. License number: 022775
29d. Date signed *(Month, Dey, Yeer)*: 10-12-97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Frederick G. Barr, M.D., 2101 Medical Park Drive, Suite 210, Silver Spring, MD 20902

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 16 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

17

WRC
97-5851-510
ROSALYN
MATZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31226

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSALYN MATZ
2. Date of Death (Month, Day, Year): OCT. 12, 1997
3. Time of Death: 5:30 PM.
4a. Facility Name (If not institution, give street and number): 3006 FALLSTAFF MANOR CT. APT. J.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-07-3637
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 4, 1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3006 FALLSTAFF MANOR CT., APT. 2-J
10f. Zip Code: 21209
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NANNY
16b. Kind of Business/Industry: CHILD CARE

17. Father's Name (First, Middle, Last): JACOB COHEN
18. Mother's Name (First, Middle, Maiden Surname): BETTY NACHLAS

19a. Informant's Name/Relationship (Type, Print): BEVERLY GOLDSTEIN (NIECE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3820 LA VISTA CIR., UNIT 121 JACKSONVILLE, FL 32217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SHOMRA SHABOS CONG. Date: 10/14/97
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Gary Fold
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Arteriosclerotic Cardiovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Aaron Lacke MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): OCT. 13, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be filed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 21,22 per F.H. G-752 10/16/97 reb

Certificate of Death

Reg. No. 97 31227

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theodore R Moore

2. Data of Death — Month: Sept; Dey: 23; Year: 1997

3. Tima of Death: 06:20

4a. Facility Nama (If not institution, giva street and number): University of Maryland Medical System

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Numbar: 214-16-3770

6. Sex: 1☒ M 2☐ F

7. Aga (In yrs. last birthday): 84 Yrs.

If Under 1 Yaar — Months: ; Deys: ; If Undar 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Oct. 12, 1912

9. Birthplaca (State or Foreign Country): unknown

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 330 S. Poppleton Street

10f. Zip Code: 21230

10g. Citizan of What Country?: U.S.A.

11. Marital Status: unknown
1☐ Navar Marriad 2☐ Marriad 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? unknown
1☐ Yes 2☐ No
If Yas, Giva Yaar or Detes:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)
1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc.
Specify: White

15. Dacedant's Education (Spacify only highest grada complatad)
Elamentary/Sacondary (0-12): unknown
Collaga (1-4or 5+): unknown

18a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired): unknown

16b. Kind of Businass/Industry: unknown

17. Fathar's Nama (First, Middla, Last): unknown

18. Mothar's Nama (First, Middle, Maidan Surnama): Ary Amos

19a. Informant's Name/Ralationship (Typa, Print): unknown

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): unknown

20a. Mathod of Disposition
1☐ Buriel 2☐ Cramation 3☐ Ramoval from Stata
4☐ Donation 5☒ Othar (Spacify) in state

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Meadowridge Mem. Park

Data: 10/2/97

20c. Location - City or Town, State: Elkridge, Md.

21. Signatura of Funaral Sarvica Licensaa: STEVEN WILLIAMS ~~Joseph B. Van Sant~~ perVR

22. Name and Addrass of Facility: GARY L. KAUFMAN FUNERAL HOME AT MEADOWRIDGE ~~State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201~~ WASHINGTON BLVD. ELKRIDGE, MD

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused tha daath. Do not antar the moda of dying, such es cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on each lina.

Approximata Intarval Batween Onsat and Death

Immadiate Ceusa (Final diseese or condition resulting in daath)
a. Myocardial Infarction — 36 hours

Dua to (or es a consequance of):

Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or injury thet initieted avants resulting in daath) Last
b.
Dua to (or as a consaquance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contributa to the cause of death?
1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Wes an autopsy performed?
1☐ Yas 2☑ No

24b. Wara autopsy findings evallabla prior to complation of ceusa of daath?
1☐ Yes 2☐ No

25. Was cesa raferrad to madical examinar?
1☐ Yas 2☑ No

28. Placa of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, ferm, straat, factory, office building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☑ **Certifying Physician**: To tha bast of my knowladga, deeth occurrad at tha tima, data and place, and dua to tha ceuse(s) and mannar as stated.
2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, dete and place, and dua to the causa(s) and mannar steted.

29b. Signetura and titla of certifiar: Melissa L. Hawkins-Holt MD

29c. License number: P 11757

29d. Data signed (Month, Day, Year): Sept. 23, 1997

30. Nama and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Melissa L. Hawkins-Holt MD 22 S. Greene St. Baltimore, MD 21201

State Registrar

31. Deta filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Luke Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in, give the funeral director, page 2 should be detached for use as the burial-transit

RB

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31228

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDNA FRANCINA MASSEY

2. Date of Death: Month 10 Day 6 Year 97

3. Time of Death: 9:00a.m.

4a. Facility Name *(If not Institution, give street and number)*: CHERRYWOOD REHAB CENTER

4b. City, Town, or Location of Death: REISTERSTOWN

4c. County of Death: REISTERSTOWN

Funeral Director

5. Social Security Number: 218-28-3346

6. Sex: 1☐ M 2☐ F XX

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10/18/12

9. Birthplace *(State or Foreign Country)*: SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 2009 MCKEAN AVE.

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- it Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest greda completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: WAITRESS

16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name *(First, Middle, Last)*: ROBERT DUREN

18. Mother's Name *(First, Middle, Maiden Surname)*: JANIE CUNNINGHAM

19a. Informant's Name/Relationship *(Type, Print)*: DOROTHY J. NELSON-DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 811 HOPEWOOD ROAD-PIKESVILLE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL PARK | Date: 10/10/97

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Bertha Hector CFSP

22. Name and Address of Facility: ELIZABETH L. PHILLIPS 1721-27 N. MONROE ST.-BALTO., MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. End Stage Renal disease

Due to (or as a consequence of):
b. diabetes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. hypertension

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

dementia

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stephen Siegel MD

29c. License number: D28304

29d. Date signed *(Month, Day, Year)*: 10/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen Siegel 750 Main Street Reisterstown MD 21136

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached by the funeral director and the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31229

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma G. Muscalli

2. Date of Death (Month, Day, Year): Oct. 13, 1997

3. Time of Death: 3:37 PM

4a. Facility Name (If not institution, give street and number): St. Elizabeth's Nursing Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-12-2166

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 31, 1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 17 E. Fort Avenue

10f. Zip Code: 21230

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line

16b. Kind of Business/Industry: McCormick's

17. Father's Name (First, Middle, Last): Monroe Lintline

18. Mother's Name (First, Middle, Maiden Surname): Freida Finke

19a. Informant's Name/Relationship (Type, Print): Norma Berlinrut (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1099 Tadcaster Road Catonsville, MD. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, cremetory or other place): Cedar Hill Cemetery

Date: 10/17/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Daniel A. Taylor

22. Name and Address of Facility: McCully-Polyniak Funeral Homes 130 E. Fort Ave., Balto., MD. 21230

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart Failure — 24hrs

Due to (or as a consequence of):

b. Ischemic Heart Disease — 5yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers Disease

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alan Dennis MD

29c. License number: D30555

29d. Date signed (Month, Day, Year): October 13, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Alan Neal Dennis 901 E. Fort Ave, Balto, MD 21230

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL MC MAHON
2. Date of Death: Month OCTOBER Day 15 Year 1997
3. Time of Death: 725 a.m
4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217 09 5062
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 31, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8043 Stone Haven Drive
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ship Builder
16b. Kind of Business/Industry: Maryland Drydock

17. Father's Name (First, Middle, Last): Michael McMahon
18. Mother's Name (First, Middle, Maiden Surname): Martha Calowell

19a. Informant's Name/Relationship (Type, Print): Joan Farkas / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7756 Woodlawn Avenue Pasadena, Maryland 21122

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 10/18/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Donna M Zaminowski
22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. BILIARY OBSTRUCTION	4 WEEKS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RECENT CHOLECYSTECTOMY

CARCINOMA COLON

INFERIOR MYOCARDIAL INFARCTION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D
29c. License number: P 11084
29d. Date signed (Month, Day, Year): OCTOBER 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BINDU GEORGE, HARBOR HOSPITAL CENTER, 3001 S. HANOVER STREET, BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Judith Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

WRC
97-5865-510
ANTWAN
MACKALL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antwan Deondre Mackall

2. Date of Death (Month, Day, Year): OCT. 13, 1997

3. Time of Death: 12:40 PM.

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL P.I.C.U.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-47-3286

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday) Yrs.: | If Under 1 Year: Months: 14 Days: 24 | If Under 24 Hrs.: Hours: Min.:

8. Date of Birth (Month, Day, Year): July 19, 1996

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1534 Sherwood Avenue

10f. Zip Code: 21239

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): n/a College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a

16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Barry Mackall

18. Mother's Name (First, Middle, Maiden Surname): Loleta Artis

19a. Informant's Name/Relationship (Type, Print): mother Loleta D. Artis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1534 Sherwood Avenue Baltimore, Md 21239

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodlawn Cemetery

Date:

20c. Location - City or Town, State: Oct 17th Baltimore County, MD

21. Signature of Funeral Service Licensee: Emmett K. Tenny Jr.

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Baltimore, MD 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocarditis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [XX] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J Chute MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): OCT. 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Burial Transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

4p

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31232

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edward E. Moore

2. Date of Death Month / Day / Year: October 13 1997

3. Time of Death: 6:37 PM

4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-54-6666

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7-13-1950

9. Birthplace *(State or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5703 Cedonia Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): NA — College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NA

16b. Kind of Business/Industry: NA

17. Father's Name *(First, Middle, Last)*: Clarence Moore

18. Mother's Name *(First, Middle, Maiden Surname)*: Lucille C. Madison

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Wagstaff - Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5703 Cedonia Avenue Balto, md 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dashiell Mem Park — Date: 10-18-97

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Rome A Thompson

22. Name and Address of Facility: March E. H. West 4300 Wabash Avenue Balto, md 21215

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis — 4 days

Due to (or as a consequence of):
b. Pneumonia — 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Renal Failure — 4 days

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

AIDS
Hyperkalemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vijay Pethkar M.D

29c. License number: D 50853

29d. Date signed *(Month, Day, Year)*: October 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 301 St. Paul Place, Baltimore MD 21202.

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Marie MYERS
2. Date of Death Month Day Year: October 11, 1997
3. Time of Death: 10:14 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-03-2893A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/16/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8800 Walther Blvd.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Joseph Strahan
18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Glenn L. Wilmer
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2305 Cloverdale Dr. Fallston, Maryland 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: 10/15/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Marion J Dippel Jr.
22. Name and Address of Facility: Dippel Funeral Home 7110 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	acute urosepsis with	Hours.
Due to (or as a consequence of): b.	Volume Depletion both	Hours.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Severe to Renal cerebrovascular accident	
Due to (or as a consequence of): d.	dehydration, and acute M.I	Hours.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: severe COPD, On Dependent. Parkinson's Disease post CVA. HTN P; neurogenic B/B post stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Michael Hyle MD
29c. License number: D27693
29d. Date signed (Month, Day, Year): 10/13/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Hyle MD 6530 Walther Blvd. Baltimore, Maryland 21236

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrer's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from page 1 as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#17 PER A. BRD. FLM#G752 10/20/97 J.A. **Certificate of Death**

Reg. No. 97 31234

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carol Lee Northam

2. Date of Death Month Dey Year: Oct. 3, 1997

3. Time of Death: 3:15 PM

4a. Facility Name *(If not institution, give street and number)*: 2516 Keyworth Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 216-44-8365

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 53 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 5, 1944

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2516 Keyworth Avenue

10f. Zip Code: 21215

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Merriad 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Wes Decadent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Wes Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amarican Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use ratired)*: Radio Announcer

16b. Kind of Business/Industry: Radio

17. Father's Neme *(First, Middle, Last)*: Lester Wayne ~~Hicldmond~~ HICKMOND

18. Mother's Nama *(First, Middle, Maiden Surnema)*: Rose Lee Glen

19a. Informent's Neme/Reletionship *(Type, Print)*: Lester Wayne Hickmond

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 209 Sandcastle Boulevard, Fruitland, Maryland 21821

20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or othar piece)*

Data

20c. Location - City or Town, Steta

21. Signature of Funaral Service Licensee: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not antar tha moda of dying, such as cardiec or raspiratory arrast, shock, or heert feilure. List only one cause on each line.

Approximeta Interval Between Onset and Deeth

Immediate Ceuse (Finel disaesa or condition resulting in deeth)

a. Lung Cancer — 1 yr

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*

Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Homa 5☑ Residence 6☐ Othar *(Specify)*

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, daeth occurred et the time, deta end place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end menner stated.

29b. Signature and titia of certifier: Richard J Diamond

29c. Licansa number: D23076

29d. Deta signed *(Month, Day, Year)*: 10-9-97

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): RICHARD L DIAMOND 3730 Falls Rd Balt MD 21211

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Reynolds

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31235

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carol Ann Neubauer

2. Date of Death Month: 10 Day: 14 Year: 97

3. Time of Death: 0554 am

4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-46-0478

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 29, 1945

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: Md.

10b. County: Howard

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7809 Millers Corner

10f. Zip Code: 21075

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Co-Owner

16b. Kind of Business/Industry: Neu Valley Nurseries

17. Father's Name *(First, Middle, Last)*: Kenneth Andrew Sipes

18. Mother's Name *(First, Middle, Maiden Surname)*: Shirley Ann Ave Maria Lauer

19a. Informant's Name/Relationship *(Type, Print)*: Pat Neubauer -husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7809 Millers Corner, Elkridge, Md. 21075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Augustine's Cemetery

Date: 10/17/97

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Steven Hall

22. Name and Address of Facility: Gary L. Kaufman Funeral Home at Meadowridge MP 7250 Washington Blvd., Elkridge, Md. 21075

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. myocardial infarction — 1 hour

Due to (or as a consequence of):
b. metastatic rectal cancer — unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon Falck MD

29c. License number: D47353

29d. Date signed *(Month, Day, Year)*: October 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jon Falck MD St. Agnes Hospital Baltimore, Maryland 21229

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. [illegible] Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: Carol Neubauer

15

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARVIN NISSLEY

2. Date of Death: Month OCTOBER Day 14 Year 1997

3. Time of Death: 4:50 PM

4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 216-42-6762

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 19 1943

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2115 Whistler Ave.

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operation Manager

16b. Kind of Business/Industry: Globe Messenger Service

17. Father's Name (First, Middle, Last): Marvin B. Nissley

18. Mother's Name (First, Middle, Maiden Surname): Gladys I. Shaffer

19a. Informant's Name/Relationship (Type, Print): Deborah L. Nissley (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2115 Whistler Ave., Baltimore, Md. 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: Oct. 17 1997

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Christina A. Kopczyk

22. Name and Address of Facility: McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Sepsis — 4 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patrice Green MD

29c. License number: A 3240232 PG 9024

29d. Date signed (Month, Day, Year): October 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Patrice Green MD, Sinai Hospital, Baltimore, Maryland

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

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H+V A

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the local registrar of vital statistics in the county where death occurred within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31237

ITEM: 21 per BONNIE ST JOS G-752 10-16-97 eok

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Osinovsky

2. Data of Death Month Dey Yaar: June 27, 1997

3. Time of Death: 6:07 AM

4e. Facility Neme (If not institution, give street and number): Saint Joseph Medical Center

4b. City, Town, or Location of Daath: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Sacurity Number: None

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday) Yrs.: If Undar 1 Yaar Months / Deys; If Under 24 Hrs. Hours: 1 Min.: 38

8. Dete of Birth (Month, Day, Year): 6/27/97

9. Birthplaca (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1805 Snowmeadow Lane, #303

10f. Zip Code: 21209

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☒ Never Merried 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Raca - American Indien, Bleck, White, atc. Specify: White

15. Decedent's Education (Specify only highast greda completed): Elementary/Secondery (0-12): 0; College (1-4or 5+): 0

16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired): None

16b. Kind of Business/Industry: None

17. Fathar's Name (First, Middle, Last): Alex Georgievich Osinovsky

18. Mother's Neme (First, Middle, Meiden Surneme): Marina Savenko Osinovsky

19e. Informent's Neme/Relationship (Type, Print): Marina Osinovsky (Mother)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1805 Snowmeadow Lane, #303, Balt., 21209

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Arlington of Chizuk

Date: 6/30/97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ SOL LEVINSON

22. Name end Addrass of Facility: Sol Levinson & Sons, Pikesville, Md.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death): e. Prematurity 18 weeks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Othar eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wera autopsy findings eveileble prior to completion of causa of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end manner as stated. 2☐ **Medical Examinar:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signature and title of certifier: ▶ Ruthann Zern, MD

29c. License number: D30622

29d. Dete signed (Month, Dey, Year): 10/9/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Ruthann Zern, M.D., 7505 Osler Dr., Towson, Maryland 21204

State Registrar

31. Dete filed (Month, Day, Yeer): OCT 16 1997

32. Registrer's Signature: Julia Davidson-Fancelli

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ike Peoples

2. Date of Death Month: Oct Day: 9 Year: 1997

3. Time of Death: 2:50 Am

4a. Facility Name (If not institution, give street and number): Bon Secour Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 417-18-5008

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 10, 1904

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1217 West Fayette Street

10f. Zip Code: 21223

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Dacadant's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unknown
College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surneme): unknown

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20e. Method of Disposition: 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other pleca)

Date

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death)
a. Klebsiella pneumonia — 14 ds

Due to (or as a consequanca of):
b. Respiratory failure — 1-2 ds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseasa or injury that initiated events rasulting in death) Lest
c.

Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Ware autopsy findings available prior to compiation of cause of death? 1 ☐ Yes 2 ☑ No

25. Was casa referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Piaca of Death (Check only ona)
Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☑ **Certifying Physician:** To the best of my knowladge, death occurred at the time, date and placa, and due to tha cause(s) and manner as stated.
2 ☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, daath occurred at tha tima, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and titie of certifier: Mien-D Kroune, MD

29c. License number: D31865

29d. Date signed (Month, Day, Year): 10/9/97

30. Name and address of person who completed cause of daath (item 23a) (Type, Print): Rm 206 821 N Gutaw street Balt md 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31239

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Iris R. Powers
2. Date of Death Month Day Year: Oct. 1, 1997
3. Time of Death: 9:30 PM
4a. Facility Name *(If not institution, give street and number)*: 4903 Edgemoore Lane
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 566-20-9691
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 12, 1917
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4903 Edgemoore Lane
10f. Zip Code: 20814
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Lee Robinson
18. Mother's Name *(First, Middle, Maiden Surname)*: Estella Ellen Dorr

19a. Informant's Name/Relationship *(Type, Print)*: Terry Powers/son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4903 Edgemoore Lane, Bethesda, Maryland 20814

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Bord, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ADENOCARCINOMA OF THE LEFT LUNG — (YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. **Did tobacco use contribute to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: James G. Brown, MD
29c. License number: D07285
29d. Date signed *(Month, Day, Year)*: OCTOBER 3, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JAMES A. BROWN MD 9707 MEDICAL CENTER DRIVE ROCKVILLE, MARYLAND 20850

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: Julia Tolson Randolph

DHMH 16 Rev 6/95

97-5642-510
B.K.S
STEVEN POPOWICZ
Items:23a part I,27,28a-f per MEO G-752 10/20/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31240

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Steven Popowicz
2. Dete of Death Month Day Yeer: OCT. 2, 1997
3. Time of Deeth: 0901 AM
4e. Fecility Neme (If not institution, give street end number): 212 LLOYD STREET
4b. City, Town, or Locetion of Death: BALTIMORE
4c. County of Daath: Baltimore City

Funeral Director

5. Sociel Security Number: unknown
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 50 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Dey, Yeer): May 20, 1947
9. Birthplece (Stete or Foreign Country): unknown

Usuei Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 212 Lloyd Street
10f. Zip Code: 21231
10g. Citizen of Whet Country?: unknown
11. Maritai Stetus: unknown — 1☐ Naver Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas?: unknown — 1☐ Yes 2☐ No If Yes, Give Yaer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): unknown — Colliega (1-4or 5+): unknown
16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown
17. Fether's Neme (First, Middle, Lest): unknown
18. Mother's Neme (First, Middle, Maiden Surname): unknown
19e. Informent's Name/Relationship (Type, Print): unknown
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): unknown
20e. Method of Disposition: 1☐ Buriai 2☐ Cremetion 3☐ Removai from State 4☐ Donation 5☒ Other (Specify) in state
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)
Dete
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Neme end Address of Feciliity: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications thet ceused the death. Do not antar the mode of dying, such es cardiac or respiretory errest, shock, or heert failura. List only one ceuse on each line. — Approximate Interval Between Onsat and Deeth

Immediete Ceuse (Finel disease or condition resulting in death): e. NARCOTIC INTOXICATION
Due to (or es e consequence of):
Sequentiolly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other signficent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco uee contributa to the ceuse of deeth?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were eutopsy findings availiable prior to completion of cause of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☒ Yes 2☐ No

26. Piece of Deeth (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Dete of Injury (Month, Dey Yeer): 10/2/97 found
28b. Time of injury: 8:30 found A M
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject ingested drugs
28e. Piece of Injury - At home, farm, streef, fectory, office building, etc. (Specify): found at home
28f. Location (Street end Number or Rural Route Number, City or Town, State): 212 Lloyd Street, Baltimore, Md.

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner es stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner steted.

29b. Signature end title of certifier: Stephen S. Nadratz, ME
29c. Licensa number: O.C.M.E
29d. Data signed (Month, Day, Year): OCT. 2, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Stephen S. Radratz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 16 1997
32. Registrar's Signature: Julia Carlton Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31241

Certificate of Death

ITEM: 1 per DR. G-752 10-16-97 eoh

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAWRENCE PRESTON (Preston, Lawrence)
2. Date of Death (Month, Day, Year): OCT 13, 1997
3. Time of Death: 630A
4a. Facility Name (If not institution, give street and number): LEVINGDALE NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: na

Funeral Director

5. Social Security Number: 062-22-1410
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 27, 1927
9. Birthplace (State or Foreign Country): FLORIDA

Usual Residence of Decedent

10a. State: MD
10b. County: na
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 XX Yes 2 ☐ No
10e. Street and Number: 4900 GREENSPRING AVENUE
10f. Zip Code: 21209
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 8 th
College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SELF EMPLOYED
16b. Kind of Business/Industry: BRICK MASON

17. Father's Name (First, Middle, Last): ED PRESTON
18. Mother's Name (First, Middle, Maiden Surname): ESTELLE PRESTON

19a. Informant's Name/Relationship (Type, Print): MARY PRESTON- WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4900 GREENSPRING AVENUE, BALTIMORE, MD

20a. Method of Disposition: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other piece): KING MEMORIAL PARK
Date: 10-18-97
20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: Anne A. Thompson
22. Name and Address of Facility: WM. C. MARCH FH.-4300 WABASH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute renal fzilure
Due to (or as a consequence of):
b. Endocarditis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Right posterior temporal cerebral infarction

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature end title of certifier: C Gerber
29c. License number: D 10660
29d. Date signed (Month, Day, Year): 10/13/97
30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): K. Weber MD - 3901 Greenspring Ave - suite #308; Balto MD 21211-1338

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Lydia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

LAWRENCE PRESTON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31242

ITEM: 1 per DR. G-752 10-16-97 eoh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~George Rogers~~ GEORGE MITCHELL RODGERS

2. Date of Death: Month: October; Day: 9; Year: 1997

3. Time of Death: 1:03 am

4a. Facility Name (If not institution, give street and number): University of Maryland Medical System

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-70-0141

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 01, 1956

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2545 WEST LOMBARD STREET

10f. Zip Code: 21223

10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11TH GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: POTATOE CHIP COMPANY

17. Father's Name (First, Middle, Last): JAMES E. RODGERS

18. Mother's Name (First, Middle, Maiden Surname): BLANCHE JOHNSON

19a. Informant's Name/Relationship (Type, Print): JAMES T. RODGERS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2545 W. LOMBARD ST, BALTIMORE, MD. 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): KING MEMORIAL PARK

Date: 10-13-97

20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 2140 N. FULTON AVE. BALTIMORE, MD. 21217

To Be Completed by Funeral Director

Terry

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Batwaen Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Sepsis

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b. Pneumonia

Due to (or es a consequence of):

c. Cirrhosis

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Yeer)

28b. Time of injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner steted.

Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signature and title of certifier: [signature] MD

29c. License number: P10219

29d. Date signed (Month, Dey, Year): October 9, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lisa Kilburg 22 South Greene Street, Baltimore, MD

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 16 1997

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31243

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rosalie Rutter

2. Date of Death Month / Dey / Year: October 13 1997

3. Time of Death: 3:38pm

4a. Facility Name *(If not institution, give street and number)*: St. Elizabeth Nursing Home

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-01-3726

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Feb. 14, 1918

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residance of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3728 Spring Falls Ct.

10f. Zip Code: 21042

10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yeer or Dates:

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Ricen, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 10 Years / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work dona during most of working life. DO NOT usa ratired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Charles Richardson

18. Mothar's Nema *(First, Middle, Maiden Surneme)*: Beatrice Durkin

19a. Informent's Name/Reletionship *(Type, Print)*: Eugene P. Rutter/Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 3728 Spring Falls Court Ellicott City, MD 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or othar place)*: Meadowridge Mem. Park

Dete: 10/16/1997

20c. Location - City or Town, State: Dorsey, Maryland

21. Signatura of Funerel Service Licensee: ▶ Johnny L. Gibbs

22. Name end Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or haart failure. List only one ceuse on eech lina.

Approximeta Intervel Batween Onsat and Death

Immediata Cause (Finel diseese or condition resulting in death)

e. Biventricular Congestive Heart Failure — 6 years

Due to (or es e consaqu ence of):

Sequentially list conditions, if eny, laading to immadiata ceuse. Enter Underlying Cause (Disaase or injury thet initiated events resulting in deeth) Last

b. Coronary Artery Disease

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other signficant conditiona** contributing to death but not rasulting in the underlying ceuse givan in Part I.

Acute Renal Failure

23b. Did tobacco uae contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yas 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Chack only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyalcian:** To tha best of my knowledga, daath occurred et the tima, data and place, and due to the cause(s) end menner es statad. 2☐ **Medical Examinar:** On the besis of examination and/or investigation, in my opinion, daath occurred et the time, dete end place, and dua to tha causa(s) end menner steted.

29b. Signature end title of certifier: ▶ Regina A. Healy MD

29c. License number: D35626

29d. Date signed *(Month, Dey, Year)*: October 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Regina A. Healy St. Agnes Health Care 3421 Benson Ave. Balto, MD 21227

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Patterson-Mendez

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31244

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS RICHARDS
2. Date of Death: Month OCTOBER Day 12 Year 1997
3. Time of Death: 7:00 AM
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-07-1025
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 4, 1918
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6101 Marietta Ave.
10f. Zip Code: 21214
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Advertising Manager
16b. Kind of Business/Industry: Baltimore Business Forms

17. Father's Name (First, Middle, Last): John G. Richards
18. Mother's Name (First, Middle, Maiden Surname): Jane Rochester

19a. Informant's Name/Relationship (Type, Print): Nancy D. Richards
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6101 Marietta Ave., Baltimore, MD 21214

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Mem. Park | Date: 10/14/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: L. Gray Altenburg
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	ASPIRATION PNEUMONIA	1 WEEK
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	5 YEARS
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maurice Bachawati, MD
29c. License number: P11399
29d. Date signed (Month, Day, Year): October 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAURICE BACHAWATI, MD; THE GOOD SAMARITAN HOSPITAL OF MARYLAND, INC

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31245

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Caroline SCHUTTIG

2. Date of Death Month: Oct. Day: 10 Year: 1997

3. Time of Death: 0325AM

4a. Facility Name *(If not Institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-14-9594

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 22, 1914

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 944 Ships Bell Court

10f. Zip Code: 21401

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claims Representative

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Clyde Egbert Gray

18. Mother's Name *(First, Middle, Maiden Surname)*: Miriam Eckford Osbourn

19a. Informant's Name/Relationship *(Type, Print)*: Leonard Aaron Schuttig/husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 944 Ships Bell Court, Annapolis, Maryland 21401

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 . Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Carcinoma of Bladder — 3 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: B.N. Rosenbaum M.D.

29c. License number: D09874

29d. Date signed *(Month, Day, Year)*: 10/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): B.N. ROSENBAUM 3720 FARRAGUT AVE. KENSINGTON, MD. 20895

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Monroe

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31246

SKARZENSKI, BENNIE JEAN

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bennie Jean Skarzenski
2. Date of Death Month/Day/Year: OCTOBER 10, 1997
3. Time of Death: 9:30 AM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 233-48-2543
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 9, 1931
9. Birthplace *(State or Foreign Country)*: W.Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2 Stuart Terrace
10f. Zip Code: 21014
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Tiano Sam
18. Mother's Name *(First, Middle, Maiden Surname)*: Tiano Beafore

19a. Informant's Name/Relationship *(Type, Print)*: Paul Skarzenski/husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2 Stuart Terrace, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION — 2-3 DAYS

Due to (or as a consequence of): CORONARY ARTERY DISEASE — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D28244
29d. Date signed *(Month, Day, Year)*: 10/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FOWZIA TAQI, M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31247

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNE P. SILVERT
2. Date of Death Month/Day/Year: OCTOBER 13 1997
3. Time of Death: 1313
4a. Facility Name (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 206-14-5029
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 23, 1923
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: TIMONIUM
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1804 EASTRIDGE RD.
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LIBRARIAN
16b. Kind of Business/Industry: LIBRARY

17. Father's Name (First, Middle, Last): ABRAHAM POLIS
18. Mother's Name (First, Middle, Maiden Surname): REBA SHALITA

19a. Informant's Name/Relationship (Type, Print): MICHAEL SILVERT (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3196 EVERGREEN DR. MURRYSVILLE, PA 15668

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM. GARDENS | Date: 10/15/97
20c. Location - City or Town, State: TIMONIUM, MD

21. Signature of Funeral Service Licensee: Sol Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	24 HOURS
Due to (or as a consequence of): b.	CARDIAC ARRHYTHMIA	12 HOURS
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	PANCREATIC WHIPPLE PROCEDURE	1½ MONTHS
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth Elaine Redd
29c. License number: A5240232 ER8586
29d. Date signed (Month, Day, Year): OCT 13 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ELIZABETH ELAINE REDD SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31248

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AEGIDIUS F SCHUH

2. Date of Death (Month, Day, Year): OCTOBER 14 1997

3. Time of Death: 2:08PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-05-8975

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 19, 1905

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8160 Riverside Drive

10f. Zip Code: 21122

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 3 | College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Building Contractor

16b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): August Schuh

18. Mother's Name (First, Middle, Maiden Surname): Florence Buckley

19a. Informant's Name/Relationship (Type, Print): Stella Lamb Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2253 Cedley Street Baltimore, Maryland 21230

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery | Date: Oct. 18, 1997

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home 3204 Mountain Road Pasadena, Maryland 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia	15 days.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disorders- Stroke

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and plece, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: [signature] HOUSESTAFF

29c. License number: AS2441614-A10

29d. Date signed (Month, Day, Year): OCTOBER 14 1997

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): [signature] SHIV KUMAR PATIL 3001 SOUTH HANOVER STREET BALTIMORE MD 21225.

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

12

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural," items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Item1 10-16-97 FilmG752 W.H.Per Doctor

97 31249

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~SLOWIKOWSKI HENRY~~ Henry Slowikowski

2. DATE OF DEATH (Month, Day, Year): OCTOBER 13, 1997

3. TIME OF DEATH: 3:00 PM

4. SOCIAL SECURITY NUMBER: 216-10-1853

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 88 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): March 15, 1909

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Church Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City

9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: N/A

10c. CITY, TOWN OR LOCATION: Baltimore City

10d. INSIDE CITY LIMITS? XX YES 2 [ ] NO

10e. STREET AND NUMBER: 431 South Durham Street

10f. ZIP CODE: 21231

10g. CITIZEN OF WHAT COUNTRY? United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 1942-45

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 XX NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6 Years
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver

16b. KIND OF BUSINESS/INDUSTRY: Transportation

17. FATHER'S NAME (First, Middle, Last): Teofil Slowikowski

18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia Zytowiecki

19a. INFORMANT'S NAME (Type/Print): Dorothy G. Adamski / Niece

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3215 Vulcan Road Dundalk, Maryland 21222

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery DATE: Oct. 17, 1997

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald R Gardner

22. NAME AND ADDRESS OF FACILITY: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS — 72 HRS.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION
HYPERTENSION

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [X] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: VMAbhyankar MD

29c. LICENSE NUMBER: D25027

29d. DATE SIGNED (Month, Day, Year): ▶ OCTOBER 13, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): VIJAY M. ABHYANKAR MD CHURCH HOSPITAL 100 N. BROADWAY BALTIMORE MD 21231

31. DATE FILED (Month, Day, Year): OCT 16 1997

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that medical certification be entered within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the medical certifier and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

571

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31250

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas T. Stewart

2. Date of Death Month: October Day: 6 Year: 1997

3. Time of Death: 1616

4a. Facility Name *(If not Institution, give street and number)*: 7831 Creek Shore Way

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 218 22 2366

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 21, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 7831 Creek Shore Way

10f. Zip Code: 21226

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 4 years +

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Minister

16b. Kind of Business/Industry: Religious

17. Father's Name *(First, Middle, Last)*: William A. Stewart

18. Mother's Name *(First, Middle, Maiden Surname)*: Julia A. Stone

19a. Informant's Name/Relationship *(Type, Print)*: Michael K. Stewart / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1701 Republic Road Silver Spring, Maryland 20902

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Hilltop Service Corp.

Date: 10/10/97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Richard E. Davis

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PARKINSONS DISEASE — 15 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen Reich

29c. License number: D37272

29d. Date signed *(Month, Day, Year)*: October 9, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stephen G. Reich, M.D., 601 N. Caroline St., S-5070, Baltimore, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Juhan Wurdson-Randolph

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached from it as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31251

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: McDonald Sanders

2. Date of Death Month Day Year: OCTOBER 12 1997

3. Time of Death: 10:40 pm

4a. Facility Name *(If not Institution, give street and number)*: GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-26-3945

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06/29/1927

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 2309 Orem Avenue

10f. Zip Code: 21217

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decadent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 5th; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Fork Lift Driver

16b. Kind of Business/Industry: Chemical Co.

17. Father's Nama *(First, Middle, Last)*: Rossie Nevelle

18. Mother's Name *(First, Middle, Maiden Surname)*: Doll Sanders

19a. Informant's Name/Relationship *(Type, Print)*: Magalena Sanders

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 2309 Orem Avenue, Baltimore, MD 21217

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* crypt

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery

Dete: 10/18

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Leroy O. Dyett

22. Name and Addrass of Facility: LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediata Cause (Final disease or condition resulting in death)

a. septic shock — 2days

Due to (or as a consequenca of):

b. perforated bowel + wound dehissence — 3days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Due to (or as e consequence of):

c. Radiation enterocolitis — 6yrs

Due to (or as e consequence of):

d. Rectal carcinoma — 7½yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

Coronary artery disease

23b. Did tobacco uee contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings evailable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be detarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Numbar or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurred at the time, date end place, and due to the cause(s) and manner statad.

29b. Signature and title of certifier: Ruth Kantor MD

29c. License number: D28594

29d. Date signed *(Month, Day, Year)*: 10/13/97

30. Neme and address of person who complated cause of death (Item 23a) (Type, Print): Ruth Kantor MD 6569 N Charles St, Suite 210, Baltimore MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Gisha Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

McDonald Sanders

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

97-5788-041
AM
RICHARD
SWINIMER
Items 23a part I,II,27,28a-f per MEO G-752 10/20/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31252

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Dete of Death Month Day Year	3. Time of Death
Richard A. Swinimer	OCTOBER 08,1997	1945 P

4e. Facility Neme (If not Institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
600 SHAW RD.	Severn	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yeer Months	If Under 1 Yeer Deys	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplace (State or Foreign Country)
220 58 2174	1[X]M 2[ ]F	45 Yrs.					Sept. 16,1952	Maryland

Usual Residence of Decedant

10e. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Anne Arundel	Baltimore	1[ ]Yes 2[X]No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4207 Fourth Street	21225	U.S.

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1[ ]Never Married 2[ ]Married 3[ ]Widowed 4[X]Divorced	1[ ]Yes 2[X]No If Yas, Give Yeer or Dates:	1[ ]Yes 2[X]No Specify:	Specify: White

15. Decedent's Education (Spacify only highest grade completed)		16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11th		Welder	Shaw Amusements

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Warren Swinimer	Lillian Truett

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 34952
Warren Swinimer / father	124 Mediterranean Blvd. N. Port St. Lucie, Fl.

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other pleca)	Deta	20c. Location - City or Town, State
1[ ]Burial 2[X]Cremation 3[ ]Removal from Stete 4[ ]Donation 5[ ]Other (Spacify)	Hilltop Service Corp.	10/13/97	Towson, Maryland

21. Signature of Funeral Service Licensee: Donna Baniewski

22. Name end Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not antar the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Intervel Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death)	e. NARCOTIC INTOXICATION	
	Due to (or as a consequanca of):	
Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated evants resulting in death) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or es a consequenca of):	
	d.	

Part Ii. **Other signilicent conditions** contributing to death but not resulting in the underlying causa given in Part I.

ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death? 1[ ]Yes 2[X]No 3[ ]Probably 4[ ]Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of daeth?
1[X]Yes 2[ ]No	1[X]Yes 2[ ]No

25. Was casa referred to medical examiner?	26. Place of Daath (Check only one)	
1[X]Yes 2[ ]No	Hospital: 1[ ]Inpatient 2[ ]ER/Outpetient 3[ ]DOA	Other: 4[ ]Nursing Homa 5[X]Residance 6[ ]Other (Specify)

27. Manner of Deeth	28a. Data of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[ ]Netural 2[ ]Accident 3[ ]Suicide 4[ ]Homicide 5[ ]Panding investigation 6[X]Could not be determined	10/8/97 found	5:40 found P M	1[ ]Yes 2[X]No	subject ingested drugs

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)
found at home	600 Shaw Road, Severn, Md.

29a. Certifier (Check only one): 1[ ] **Certifying Phyaicien**: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) and menner es stated.
2[X] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, daath occurred at the time, data and placa, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz MD	OCME	OCTOBER 09,1997

30. Name end eddress of person who complated causa of daath (Item 23a) (Type, Print)
Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 16 1997	Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 25 per T.T G-752 10-16-97 eoh

Certificate of Death

Reg. No. 97 31253

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Albert Shockley

2. Dete of Deeth — Month: SEPTEMBER Dey: 24 Yeer: 1997

3. Time of Death: 10:00 PM

4e. Fecility Neme (If not institution, give street end number): Saint Joseph Medical Center

4b. City, Town, or Location of Deeth: Towson

4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 221-16-9929

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): April 9, 1929

9. Birthplace (Stete or Foreign Country): Delaware

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street end Number: 311 Cree Terrace

10f. Zip Code: 21911

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1952-54

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 — College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Electrical Technician

16b. Kind of Business/Industry: unknown

17. Fether's Name (First, Middle, Lest): Clarence Albert Shockley

18. Mother's Neme (First, Middle, Maiden Surneme): Mildred Lynch

19a. Informent's Neme/Reletionship (Type, Print): Patricia Haskell/daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 621 Shuboro Street, Vista, CA 92083

20e. Method of Disposition: 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☒ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)

Dete

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Joseph B. Van Sant

22. Neme end Address of Fecility: State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. IDIOPATHIC DILATED CARDIOMYOPATHY

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causs of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Piece of Deeth (Check only one): Hospitel: 1 ☒ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Deeth: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Francis Khoo

29c. License number: D30263

29d. Dete signed (Month, Dey, Yeer): 09-25-97

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): FRANCIS KHOO M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randelle

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

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State of Maryland / Department of Health and Mental Hygiene 97 31254

ITEM#10a PER A. BRD. FLM#G752 10/20/97 J.A. **Certificate of Death**

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELZAPO TERRELL

2. Date of Death Month: OCT Day: 7 Year: 1997

3. Time of Death: 9:26 AM

4a. Facility Name (If not institution, give street and number): 7600 Carroll Avenue

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-58-2834

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 27, 1941

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: D.C. ~~Maryland~~

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 635 Lamont Street, N.W.

10f. Zip Code: 20010

10g. Citizen of What Country? U.S.A.

11. Marital Status: unknown
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown
1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): unknown
College (1-4 or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State
4 [ ] Donation 5 [X] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure — 5 years

Due to (or as a consequence of):
b. Cardiomyopathy — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary Disease

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D08546

29d. Date signed (Month, Day, Year): OCT. 7. 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John Lauber 8218 Wisconsin Ave Bethesda MD.

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31255

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick R.Vernon-Williams
2. Date of Death (Month, Dey, Yeer): OCTOBER 8,1997
3. Time of Death: 09:40
4a. Facility Name (If not institution, give street end number): MEMORIAL HOSPITAL AT EASTON
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 213-09-7124
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): Nov. 27, 1913
9. Birthpiece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 510 Diamond Street
10f. Zip Code: 21601
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Journalist/Photographer
16b. Kind of Business/Industry: Newspaper

17. Fether's Neme (First, Middle, Last): Frederick Vernon-Williams Sr.
18. Mother's Neme (First, Middle, Meiden Surneme): Ida Thomas Miller

19a. Informent's Name/Reietionship (Type, Print): Eleanor Vernon-Williams/wife
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 510 Diamond Street, Easton, Maryland 21601

20a. Method of Disposition: 1☐ Buriei 2☐ Cremetion 3☐ Removel from State 4☒ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece):
Dete:
20c. Location - City or Town, Stete:

21. Signeture of Fuiterel Service Licensee: Ronald B. Wade, Director
22. Neme end Address of Feciiity: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or compiications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feiiure. List only one ceuse on eech line.

Approximete Intervei Between Onset end Deeth

Immediete Cause (Finei diseese or condition resulting in deeth): e. Ruptured Thoracic Aortic Aneurysm — 3hrs.
Due to (or es e consequence of):
b. Hypertension — >10yrs.
Sequentiiiy list conditions, if eny, leeding to immediete cause. Enter Underiying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic renal insufficiency, Congestive Heart Failure, Alcohol Abuse

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveiieble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicei examiner? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ Medicel Exeminer: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: J. Hollywood MD
29c. License number: D46820
29d. Dete signed (Month, Dey, Yeer): 10/8/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 16 1997
32. Registrer's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

Frederick R Vernon Williams

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 23b,c per DR. G-752 10-16-97 eoh

Certificate of Death

Reg. No. 97 31256

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Joseph Louis Weidenhan
2. Date of Deeth — Month: October Dey: 4 Yeer: 1997
3. Time of Deeth: 8:55AM
4e. Fecility Neme (If not institution, give street end number): Charlestown Care Center
4b. City, Town, or Location of Deeth: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-6737
6. Sex: 1☒ M 2☐ F
7. Aga (In yrs. last birthdey): 90 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): June 22, 1907
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 715 Maiden Choice Ln
10f. Zip Code: 21228
10g. Citizan of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+): 2
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Manager - Baltimore Gas & Electric - Utility
16b. Kind of Business/Industry:

17. Fether's Neme (First, Middle, Last): unknown
18. Mother's Neme (First, Middle, Meiden Surneme): unknown

19e. Informent's Name/Reletionship (Type, Print): Clare W. Sutton/daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 21 Ivy Rd, Wilmington, DE 19806

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Hampstead Cemetery — Dete: 10/7/97
20c. Location - City or Town, Stete: Hampstead, MD

21. Signeture of Funerel Service Licensee: ▶ Jeffrey B Eline
22. Neme end Address of Fecility: 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immedieta Cause (Finel diseese or condition resulting in death):
e. Heart failure — years

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to Immediate causa. Enter Underlying Ceuse (Disaase or injury thet initiated evants resulting in deeth) Lest
b. ISCHEMIC HEART DISEASE

Due to (or es a consequence of):
c. ATHEROSCLURIS

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☐ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ MD
29c. License number: D47009
29d. Dete signed (Month, Dey, Yeer): October 4, 1997

30. Neme end eddress of person who completed causa of deeth (Item 23e) (Type, Print): Phillip Stone 711 Maiden Choice Lane, Catonsville MD 21228

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 16 1997
32. Registrar's Signature: ▶ Julia Davidson-Kendall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-5704-031

HAROLD MICHAEL WRIGHT

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31257

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAROLD MICHAEL WRIGHT

2. Date of Death (Month, Day, Year): OCTOBER 08 1997

3. Time of Death: 1:55 a

4a. Facility Name *(If not institution, give street and number)*: COLESVILLE RD. & GEORGIA AVE

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 283-80-6533

6. Sex: XX 1 M 2 ☐ F

7. Age *(In yrs. last birthday)*: 26 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR. 14, 1971

9. Birthplace *(State or Foreign Country)*: MISSISSIPPI

Usuet Residanca of Decedent

10a. State: MARYLAND

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1 ☐ Yes XX No

10e. Street and Number: 6308 BRIGHT PLUME

10f. Zip Code: 21044

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? XX Yes 2 ☐ No If Yas, Give Year or Dates: GULF WAR

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 ☐ Yas XX No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Eduestion *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 1

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CARETAKER ALAT

16b. Kind of Business/Industry: NATIONAL INSTITUTE HEALTH

17. Fether's Nema *(First, Middle, Last)*: HENRY M. WRIGHT

18. Mother's Name *(First, Middle, Meiden Surname)*: CAROL LINDSEY

19a. Informent's Name/Raletionship *(Type, Print)*: HENRY M. WRIGHT (FATHER)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6308 BRIGHT PLUME COLUMBIA MARYLAND 21044

20a. Method of Disposition: 1 X Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: CHELTENHAM-MARYLAND VETERANS CEMETERY

Date: OCT. 14, 1997

20c. Location - City or Town, Stete: CHELTENHAM MARYLAND

21. Signeture of Funerel Service Licensee: Robert [illegible]

22. Neme end Address of Facility: WITZKE FUNERAL HOME, INC. OF COLUMBIA 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 shall be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is completed as an "natural", or items 23a or 28a-f show any injury or other circumstance that the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Pert1. Entar tha disaasa, or complications that caused the death. Do not anter tha mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. — Approximete Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in deeth)

e. Multiple Injuries

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was en autopsy performed? X Yes 2 ☐ No

24b. Ware autopsy findings eveileble prior to complation of ceuse of death? X Yes 2 ☐ No

25. Was case referred to medicel exeminar? 1 X Yes 2 ☐ No

26. Plece of Death *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other *(Specify)* SCENE

27. Manner of Deeth: 1 ☐ Netural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*: 10/8/97

28b. Time of Injury: 155 AM

28c. Injury et Work? 1 ☐ Yes 2 X No

28d. Describe how injury occurred: Subject struck fixed objects and vehicle caught

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: roadway

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*: Colesville Road and Georgia Avenue in Silver Spring Maryland

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Phyeicien:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) end mennar as steted. 2 X **Medicel Exeminar:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceusa(s) end menner stated.

29b. Signeture end title of certifier: Theodore M. Kirp

29c. License number: O.C.M.E

29d. Date signed *(Month, Dey, Year)*: OCTOBER 08, 1997

30. Neme end eddress of person who completed ceusa of deeth (Item 23e) (Type, Print): THEODORE M. Kirp 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Year)*: OCT 16 1997

32. Registrar's Signature: Ruby Davidson-Randolph

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31258

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Conrad B. Wengert Jr.

2. Date of Death Month: October Day: 11th Year: 1997

3. Time of Death: 2:50 Am

4a. Facility Name *(If not institution, give street end number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214 66 3684

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: May 10, 1955

9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 122 Bar Harbor Road

10f. Zip Code: 21122

10g. Citizen of Whet Country?: U.S.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Welder

16b. Kind of Business/Industry: Trucking

17. Father's Name *(First, Middle, Last)*: Conrad B. Wengert Sr.

18. Mother's Name *(First, Middle, Meiden Surneme)*: Dolores M. Wager

19a. Informent's Name/Relationship *(Type, Print)*: Dolores M. Wengert / mother

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 122 Bar Harbor Road Pasadena, Maryland 21122

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Hilltop Service Corp.

Date: 10/13/97

20c. Location - City or Town, Stete: Towson, Maryland

21. Signature of Funeral Service Licensee: Richard E. Davis

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finat diseese or condition resulting in death): a. metastatic cancer — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other signficent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, In my opinion, death occurred at the time, date and ptace, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D48006

29d. Date signed *(Month, Dey, Yeer)*: October 11th, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KOFi OWUSU-BOAITEY, 301 Hosp. Dr, Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be included within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

WENGERT, CONRAD B

97-5835-510

ROBERT WILLIAMS

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31259

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert D. Williams

2. Date of Death (Month, Day, Year): OCTOBER 11 1997

3. Time of Death: 2219 P

4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-86-6260

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 23 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3-3-74

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: Md. | 10b. County: N/A | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2319 E. Madison Street | 10f. Zip Code: 21205 | 10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABOR

16b. Kind of Business/Industry: 4 A's Bail Services

17. Father's Name (First, Middle, Last): Robert D. Williams Jr.

18. Mother's Name (First, Middle, Meiden Surname): Barbra Elliott

19a. Informant's Name/Relationship (Type, Print): Barbra Elliott - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21045: 5764 Steven Forest Rd Apt 203 Balto. md

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): King's Memorial Park | Date: 10/18/97

20c. Location - City or Town, State: Randallstown md.

21. Signature of Funeral Service Licensee: Jeff Miller

22. Name and Address of Facility: 1639 N. Broadway Balto. md. 21213. Jeff Miller P.C. Funeral Home & Service

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Wes cese referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 10-11-97

28b. Time of Injury: 2159 M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how Injury occurred: Dirt-Bike Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Street

28f. Location (Street and Number or Rural Route Number, City or Town, State) Milton and Oliver Baltimore City, Maryland

29e. Certifier (Check only one): 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2 ☒ Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, death occurred at the time, date and piace, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: Stephen S. Nacly, MD

29c. License number: O.C.M.E

29d. Date signed (Month, Dey, Year): OCTOBER 12, 1997

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Year): OCT 16 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

3

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31260

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Weber

2. Date of Death — Month: October; Day: 13; Year: 1997

3. Time of Death: 11:45 PM

4a. Facility Name *(If not institution, give street and number)*: Mariner Health Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-07-3332

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth *(Month, Day, Year)*: 12/25/1899

9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Fallston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1332 Cydonia Rd.

10f. Zip Code: 21047

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 4th

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Domestic

17. Father's Name *(First, Middle, Last)*: Michael Kolodzieski

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Josephine Szarek / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1332 Cydonia Rd. Fallston, Maryland 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holy Rosary Cemetery

Date: 10/18/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber

22. Name and Address of Facility: David J. Weber Funeral Home 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — 2 month

Due to (or as a consequence of):

b. Hypertension — 20 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*

1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D34652

29d. Date signed *(Month, Day, Year)*: October 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 16 1997

32. Registrar's Signature: Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Frances Weber

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31261

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY L. WEBER
2. Date of Death Month Day Year: OCTOBER 14, 1997
3. Time of Death: 8:50P
4a. Facility Name (If not institution, give street and number): 1219 NORTH AVENUE
4b. City, Town, or Location of Death: ARBUTUS
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-05-6125
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 25, 1913
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: ARBUTUS
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1219 NORTH AVENUE
10f. Zip Code: 21227
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yas, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Ricen, atc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: CEMETERY

17. Father's Name (First, Middle, Last): GEORGE E. WEBER
18. Mother's Nama (First, Middle, Maiden Surnama): OTILLIE SCHAFER

19a. Informant's Name/Relationship (Type, Print): GLADYS WEBER/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1219 NORTH AVENUE ARBUTUS, MD 21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): LOUDON PARK MAUSOLEUM
Date: 10/17/97
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Anthony L. DiMuzio
22. Name and Address of Facility: LOUDON PARK FUNERAL HOME 3620 WILKENS AVENUE BALTIMORE, MD 21229

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter tha moda of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

		Approximate Intervel Between Onset and Death
Immediete Cause (Final disease or condition resulting in death)	a. CAD	10 years
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest	b. Due to (or as a consequence of): CHF	7 years
	c. Due to (or as a consequence of): CRF	5 yrs
	d. Due to (or as a consequence of):	

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to compiation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurrad at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D26294
29d. Date signed (Month, Dey, Year): 10/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1101 Maiden Choice Lane, Baltimore, MD 21229

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31262

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Steve Zaiko

2. Date of Death (Month, Day, Year): October 13, 1997

3. Time of Death: 12:07 pm

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-07-8948

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 6, 1920

9. Birthplace (State or Foreign Country): Glen Arm, Md.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Kingsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11610 Stocksdale Road

10f. Zip Code: 21087

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 8/2/43 - 8/31/44

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12 yrs.

College (1-4or 5+): 2yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer

16b. Kind of Business/Industry: Federal Aviation Admin.

17. Father's Name (First, Middle, Last): Wesley Zaiko

18. Mother's Name (First, Middle, Maiden Surname): Agafia (Unknown)

19a. Informant's Name/Relationship (Type, Print): Doris Zaiko (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11610 Stocksdale Road Kingsville, Md. 21087

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Trinity Russian Cemetery

Date: 10/16/97

20c. Location - City or Town, State: Elkridge, Maryland 21075

21. Signature of Funeral Service Licensee: E. F. Lassahn

22. Name and Address of Facility: E. F. Lassahn Funeral Home, 11750 Belair Road Kingsville, Maryland 21087

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Left. lobar atelectasis, Severe Hypoxaemia — 2 weeks.

Due to (or as a consequence of):

b. Respiratory failure. — 4 months.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Ascitis, Cirrhosis of Liver.

Due to (or as a consequence of):

d. Alcoholism.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Bronchitis.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 18424

29d. Date signed (Month, Day, Year): OCT/ 13/ 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. D. PAREKH MD. 1908 HARFORD ROAD FALLSTON, MD. 21047.

State Registrar

31. Date filed (Month, Day, Year): OCT 16 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Zaiko, Steve

12/1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31263

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KENNETH MERLE AUGHENBAUGH SR

2. Date of Death (Month, Day, Year): September 30, 1997

3. Time of Death: 4:20 p.m.

4a. Facility Name (If not institution, give street and number): Physicians Memorial Hospital

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 194-16-5630

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV 9 1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: St Mary's

10c. City, Town or Location: Charlotte Hall

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: Route 2 Box 5

10f. Zip Code: 20622

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Merle Aughenbaugh

18. Mother's Name (First, Middle, Maiden Surname): Janet Harvey Aughenbaugh

19a. Informant's Name/Relationship (Type, Print): Mary A. Bocchetti (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 North Wisner St Frederick, MD 20701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Alto Rest Cem. Date: 10-7-97

20c. Location - City or Town, State: Altona, PA

21. Signature of Funeral Service Licensee: John A. Eberwein M00173

22. Name and Address of Facility: J.H. Eberwein Mortuary, 4433 White Pls La White Pls., MD 29695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. RESPIRATORY FAILURE — 1HRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. CARINOMA OF LUNG — FEWYRS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Ralph Altemus

29c. License number

29d. Date signed (Month, Day, Year): SEPT 30 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Ashvin J.Patel, MD, 603 Post Office Road, Suite 207, Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year): OCT 06 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31264

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Andrews

2. Date of Death Month: September Day: 17 Year: 1997

3. Time of Death: 1429

4a. Facility Name *(If not institution, give street and number)*: R Adams Cowley Shock Trauma Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-02-4136

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 17 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 14, 1980

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1290 Graff Court Apt.2B

10f. Zip Code: 21403

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver

16b. Kind of Business/Industry: Refuse Company

17. Father's Name *(First, Middle, Last)*: John E. Andrews Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Donna Scott

19a. Informant's Name/Relationship *(Type, Print)*: Donna Scott Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1115 East Fourth Street, Lampasas, TX. 76550

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakemont Cemetery

Date: 9-22-97

20c. Location - City or Town, State: Davidsonville, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, 147 Duke of Gloucester Street Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Retroperitoneal Hematoma	20 min.
Due to (or as a consequence of):	b. Blunt Abdominal Trauma	20 min.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Motor Vehicle Crash	20 min.
Due to (or as a consequence of):	d.	

Theodore M. Kim sub for Dr. David Fowler

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: 9/17/97

28b. Time of Injury: 1315 [X] AM [ ] PM

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred: SUBJECT WAS EJECTED PASSENGER

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: ROADWAY

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: ROUTE #291 & ROUTE 301

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William C Chiu, M.D.

29c. License number: 046147

29d. Date signed *(Month, Day, Year)*: 9/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William C Chiu, M.D., R Adams Cowley Shock Trauma Center, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 24 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31265

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Carl Almacy III

2. Date of Death (Month, Day, Year): SEPTEMBER 30 1997

3. Time of Death: 9:05pm

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 210-14-9982

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 20, 1926

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2513 Hanson Road

10f. Zip Code: 21040

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-1974

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Military

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): John Carl Almacy II

18. Mother's Name (First, Middle, Maiden Surname): Katherine (UNK) Sable

19a. Informant's Name/Relationship (Type, Print): Herta Almacy/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2513 Hanson Road, Edgewood, MD 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Bel Air Memorial Gardens

Date: 10/4/97

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas III

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE SYSTEM ORGAN FAILURE

Due to (or as a consequence of):

b. SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. BOWEL ISCHEMIA / GANGRENE

Due to (or as a consequence of):

d. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: VMAbhyankar MD

29c. License number: D25027

29d. Date signed (Month, Day, Year): OCTOBER 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIJAY M. ABHYANKAR 200 MILTON AVENUE FALLSTON MD 21047

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

JOHN CARL ALMACY

1 of 2

State Registrar

31. Date filed (Month, Day, Year): OCT 3 1997

32. Registrar's Signature: Jacqueline Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31266

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCIS WILLIAM BENNETT
2. Data of Death — Month: SEPT. Day: 24 Year: 1997
3. Time of Death: 12:58AM
4a. Facility Name *(If not institution, give street and number)*: PHYSICIANS MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: LAPLATA
4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 218-16-3162
6. Sex: 1 [X] M 2 [ ] F
7. Aga *(In yrs. last birthday)*: 76 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: May 8,1921
9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Residance of Decadant

10a. Stata: Maryland
10b. County: Charles
10c. City, Town or Location: La Plata
10d. Insida City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: Mudd Farm Lane
10f. Zip Coda: 20646
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Marriad 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yas [X] No — If Yes, Giva Yaar or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas [X] No *Specify:*
14. Reca - American Indian, Black, Whita, atc. *Specify:* Black

15. Decedant's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 3 — Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tenant Farmer
16b. Kind of Business/Industry: Farming

17. Fathar's Name *(First, Middle, Last)*: Jim Bennett
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Margaret Collins

19a. Informant's Name/Ralationship *(Type, Print)*: Ronald J. Queen, Friend
19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 315 Jennie Run Drive, La Plata, Md. 20646

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Placa of Disposition *(Name of cametery, crematory or other place)*: Sacred Heart Cemetery — Data: 9/29/97
20c. Location - City or Town, Stete: La Plata, Md.

21. Signatura of Funaral Service Licansee: ▶ J. C. Echols Jr. M-00174
22. Name and Address of Facility: AREHART - ECHOLS FUNERAL HOME ,INC. P.O. BOX 567 , LA PLATA,MD. 20646

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haert failura. List only ona causa on aach lina. — Approximeta Intarval Batween Onset and Death

Immediete Ceuse (Final disaasa or condition resulting in daath)
e. Artenosclerotic Cardiovascular Disease
Due to (or as a consequance of):

Sequantially list conditions, if any, laading to immadieta causa. Entar Underlying Causa (Disaase or injury that initiated events rasulting in death) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yss 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Wera autopsy findings available prior to complation of cause of daath? 1 [ ] Yas 2 [ ] No

25. Was case refarrad to medical examinar? 1 [ ] Yas 2 [ ] No
26. Place of Death *(Check only one)* — Hospital: 1 [/] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidanca 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [/] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1 [ ] **Certifying Phyalcian**: To tha best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) end manner es steted. 2 [/] **Medical Examiner**: On tha basis of axamination end/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the ceuse(s) and mannar statad.
29b. Signeture and title of cartifier: ▶ [illegible] MD
29c. Licansa number: 027348
29d. Data signed *(Month, Day, Year)*: 9/25/97
30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print): [illegible] Suite 100 700 Old Lve Center Waldorf, md 20602

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 0 3 1997
32. Registrar's Signatura: ▶ Julia Davidson Randall

DHMH 16 Rsv 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit

FRANCIS BENNETT

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31267

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dominic Badini
2. Date of Death (Month, Day, Year): October 4, 1997
3. Time of Death: 2:57AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-14-6900
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 22, 1920
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6504 Spring Brook Lane
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1941-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Builder
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): A. ames Badini
18. Mother's Name (First, Middle, Maiden Surname): Tillie Unknown Nicastri

19a. Informant's Name/Relationship (Type, Print): Doris Badini (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6504 Spring Brook Lane Clinton, Maryland 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland State Veterans Cem. — Date: Oct. 8, 1997
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac arrest.	
Due to (or as a consequence of): b.	Multisystem failure	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Hx of CAD, CABG, Severe Peripheral	Years
d.	Vascular disease, (R) foot gangrene s/p Rt BKA	Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D45435
29d. Date signed (Month, Day, Year): 10/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Darkey Mathews MD Southern Maryland Hospital

State Registrar

31. Date filed (Month, Day, Year): OCT 07 1997
32. Registrar's Signature: Julia Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31268

ESTHER F. BALCEREK

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner | **Funeral Director** | **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): Esther F. Balcerek
2. Date of Death: Month: September; Day: 18; Year: 1997
3. Time of Death: 8:20 PM
4a. Facility Name (If not institution, give street and number): North Arundel Hospital
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel
5. Social Security Number: 390-07-2084
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 12, 1911
9. Birthplace (State or Foreign Country): Wisconsin

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 395 Gambel Oak Court
10f. Zip Code: 21108
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Retail Department Store

17. Father's Name (First, Middle, Last): Peter Wojciechowski
18. Mother's Name (First, Middle, Maiden Surname): Martha Snarnovski

19a. Informant's Name/Relationship (Type, Print): Barbara Gillespie/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 395 Gambel Oak Court, Millersville, MD 21108

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Sept19 1997
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner | **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Congestive Heart Failure — Months.
Due to (or as a consequence of):
b. Dementia — Days
Due to (or as a consequence of):
c. Sepsis — Days
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D40535
29d. Date signed (Month, Day, Year): 9/18/97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rudolf Ritanji, M.D. North Arundel Hospital

State Registrar

31. Date filed (Month, Day, Year): SEP 22 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31269

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert O. Bowie

2. Date of Death Month / Day / Year: September 19, 1997

3. Time of Death: 12:33 p.m.

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 218-36-8381

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 3 1942

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6216 FLAMINGO DRIVE

10f. Zip Code: 21060

10g. Citizen of What Country?: US

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 2 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MAINTANCE ENGINEER

16b. Kind of Business/Industry: ANNE ARUNDEL COUNTY HOUSING AUTHORITY

17. Father's Name *(First, Middle, Last)*: ROBERT BOWIE CHASE

18. Mother's Name *(First, Middle, Maiden Surname)*: DOTHORY BEANE

19a. Informant's Name/Relationship *(Type, Print)*: ANNIE M. BOWIE (WIFE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6216 FLAMINGO DR. GLEN BURNIE, MD. 21060

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY

Date: 9/27/97

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Harry D. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Cardiogenic Shock — 40 min

Due to (or as a consequence of):
b. Pulseless Electrical Activity. — 40 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Hypoxemia — 40 min.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☑ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Tet Wei Chan

29c. License number: D50748

29d. Date signed *(Month, Day, Year)*: 9/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TET WEI CHAN 1600 Crain Hwy, Ste 605 Glen Burnie MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31270

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Ruth Bailey

2. Date of Death: Month: September Day: 26 Year: 1997

3. Time of Death: 1105 pm

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-22-1487

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Sept. 26, 1906

9. Birthplece (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2620 Clayton Road

10f. Zip Code: 21085

10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American indien, Black, White, etc. Specify: White

15. Decedent's Eduestion (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Thomas Andrew Riley

18. Mother's Name (First, Middle, Melden Surneme): Emma (nmn) Beckley

19a. Informent's Neme/Reletionship (Type, Print): Thelma Anderson, Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2620 Clayton Road, Joppa, Md. 21085

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Centre UM Church Cemetery

Dete: 9/29/97

20c. Locetion - City or Town, State: Forest Hill, Maryland

21. Signeture of Funeral Service Licensee: Charles A. Emge

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland21014

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete intervel Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)

a. acute myocardial infarction

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

b. coronary artery disease

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

Severe aortic stenosis

dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one) Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of injury (Month, Dey Year)

28b. Time of injury M

28c. injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: Henry Jan Klein

29c. License number: D37364

29d. Date signed (Month, Dey, Year): Sep 27, 1997

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print): 19 Walnut Lane, Aberdeen Maryland

State Registrar

31. Dete filed (Month, Dey, Year): SEP 29 1997

32. Registrar's Signature: Jacqueline Randall

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Bailey, Ruth

3
10a

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31271

Reg. No.

Item#5 per FH G758 4/3/98 RB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Virginia Jones Blackston

2. Date of Death: Month Sept. Day 30, Year 1997

3. Time of Death: 1:20 AM

4a. Facility Name (If not institution, give street and number): Mallard Bay Nursing & Rehab. Center

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 213-14-6761 ~~178-44-6808~~

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 20, 1923

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 737 Rigby Avenue

10f. Zip Code: 21613

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Billing Clerk

16b. Kind of Business/Industry: Bell Atlantic Telephon

17. Father's Name (First, Middle, Last): Edward Jones, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Della Stanley

19a. Informant's Name/Relationship (Type, Print): Constance Elliott, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 737 Rigby Avenue, Cambridge, Md. 21613

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Thompsontown Cemetery

Date: 10/7/97

20c. Location - City or Town, State: Thompsontown, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Bennie Smith Funeral Home, P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebrovascular Disease	3 yrs
Due to (or as a consequence of): b.	Multiple Strokes	3 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Fadden MD

29c. License number: D26388

29d. Date signed (Month, Day, Year): 10-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fadden MD 302 Collins, Hurlock md 21643

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31272

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNA LUTHRINGER BONSALL

2. Date of Death Month / Day / Year: SEPT. 30 1997

3. Time of Death: 21:10

4a. Facility Name *(If not institution, giva street and numbar)*: Laurelwood Nursing Home

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-26-4180

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.: 96

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Feb 26 1901

9. Birthplece *(Steta or Foraign Country)*: Cecilton MD

Usual Rasidence of Dacedant

10a. Stata: MD

10b. County: Cecil

10c. City, Town or Location: Cecilton

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street end Numbar: Earleton Village, Center St.

10f. Zip Coda: 21913

10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐ Naver Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detes:

13. Was Decedant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, alc. *Specify:* white

15. Decedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 11 / Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: homemaker

16b. Kind of Businass/Industry: home

17. Fethar's Nama *(First, Middla, Last)*: William Luthringer

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Daisy Hague

19a. Informant's Name/Raletionship *(Type, Print)*: Daisy Torrance (niece)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 701 Prospect Ave. Wilm. DE 19808

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, crematory or othar placa)*: Zion Cemetery

Date: 10/3/97

20c. Location - City or Town, Stata: Cecilton, MD

21. Signature of Funaral Sarvica Licensea: M00510

22. Nama and Address of Facility: Galena F.H.of Stephen L. Schaech Box 235 118 W. Cross St. Galena MD21635

Physician /Medical Examiner

23a. Part I. Entar tha disaese, or complicetions that caused tha daeth. Do not anter tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart feilura. List only ona causa on aach lina.

Approximate Interval Between Onset and Deeth

Immedieta Causa (Final diseasa or condition resulting in daath)

a. Cerebro vascular accident — 5yrs

Due to (or es e consequence of):

b. Meningioma — 5yrs.

Sequantially list conditions, if any, leading to immediata cause. Entar Underlying Ceuse (Disaasa or injury that initiatad avants rasulting in daath) Lest

Due to (or as a consaquanca of):

c.

Dua to (or es e consaquanca of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy parformed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa refarred to medical axaminar? 1☐ Yas 2☒ No

26. Plece of Deeth *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Manner of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not ba datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurred at the tima, data and place, end dua to tha causa(s) and mannar as stated. 2☐ **Madical Examinar:** On tha basis of examinetion and/or Investigation, in my opinion, daath occurred at the time, deta and place, and due to the cause(s) end mannar statad.

29b. Signature end titla of certifiar: Wallace Obenshain MD

29c. Licensa number: D07129

29d. Date signed *(Month, Day, Yaar)*: oct 1, 1997

30. Nema and address of person who complated cause of death (Item 23a) (Type, Print): Wallace B. Obenshain MD Box 415 Cecilton, MD 21913

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 01 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31273

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Earl Lee Barker

2. Date of Deeth — Month: September; Dey: 30; Year: 1997

3. Time of Death: 13:50

4e. Feclity Neme *(If not institution, give street and number)*: 6 North St. Augustine Road

4b. City, Town, or Location of Deeth: Chesapeake City

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 246-38-8567

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Yeer — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Yeer)*: February 13 1930

9. Birthplace *(Stete or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Cecil

10c. City, Town or Location: Chesapeake City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6 North St. Augustine Road

10f. Zip Code: 21915

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Deteс: US Navy 1948-1956

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Line Foreman

16b. Kind of Business/Industry: Electric Motor Assembly Plant

17. Fether's Neme *(First, Middle, Last)*: Luther V. Barker

18. Mother's Neme *(First, Middle, Meiden Surname)*: Lucy Hart

19e. Informent's Neme/Reletionship *(Type, Print)*: Elizabeth M. Barker / Spouse

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6 N. St. Augustine Road, Chesapeake City MD 21915

20e. Method of Disposition: 1☒ Burie 2☐ Cremetion 3☐ Removei from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: North East Methodist Cem.

Dete: Oct. 3 1997

20c. Location - City or Town, Stete: North East, Maryland

21. Signature of Funeral Service Licensee: Robert H. Crouch

22. Neme end Address of Feciliity: Crouch Funeral Home, 127 South Main Street, North East, MD 21901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death)
e. METASTATIC CA — 1995

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last
b.

Due to (or as a consequence of):
c.

Due to (or es a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Thomas E. Finucan

29c. License number: D32395

29d. Dete signed *(Month, Dey, Yeer)*: 09-30-97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Thomas E. Finucan 3 Mauldin Avenue, North East MD 21901

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 02 1997

32. Registrar's Signeture: Jacqueline Hamilton-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ira T. Brown

2. Date of Death: Month: October Day: 2 Year: 1997

3. Time of Death: 17:30

4a. Facility Name (If not institution, give street and number): Medpointe Continuing Care Facility

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 176-07-2066

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 7, 1903

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Perryville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 55 Cherry Lane

10f. Zip Code: 21903

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor Office Services/Maintenance

18b. Kind of Business/Industry: Steel Manufacturing

17. Father's Name (First, Middle, Last): Charles Henry Brown

18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Midgley

19a. Informant's Name/Relationship (Type, Print): Charles Brown / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1202 Scott Drive, Coatesville, PA 19320

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview Cemetery

Date: Oct. 6 1997

20c. Location - City or Town, State: Coatesville, Penna.

21. Signature of Funeral Service Licensee: Robert L. Crouch

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North Esat, MD 21901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 1 day

Due to (or as a consequence of):

b. Coronary Artery Disease — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sachdev S MD

29c. License number: D23322

29d. Date signed (Month, Day, Year): 10/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S SACHDEV MD 118 North St Suite BB ELKTON MD 21921

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Linda Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31275

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Marie Bitner

2. Date of Death Month / Day / Year: October 3 1997

3. Time of Death: 0450

4a. Facility Name *(If not institution, give street end number)*: Laurelwood Nursing Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-32-1849

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: April 28, 1905

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Port Deposit

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 94 North Main Street

10f. Zip Code: 21904

10g. Citizen of What Country?: U.S.A.

11. Marital Status: ☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Six Years | College (1-4or 5+): --------

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress

16b. Kind of Business/Industry: Winchester's Restaurant Port Deposit, Maryland

17. Father's Name *(First, Middle, Last)*: Francis T. Bitner

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Agnes Duke

19a. Informent's Name/Relationship *(Type, Print)*: H. Teresa Bitner (sister)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 94 North Main Street, Port Deposit, Maryland 21904

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Brookview Cemetery

Date: 10/7/97

20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903-0188

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death) e. Pneumonia — 3 days

Due to (or es e consequence of):

Sequentially list conditions, if any, ieeding to immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert i.

Dementia

FX Hip

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: D 44102

29d. Date signed *(Month, Dey, Year)*: 10/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Renzulli 901 Warburton Rd Elkton MD 21921

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31276

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PHYLLIS CHRISTINE BARTON

2. Data of Death Month Day Yaer: SEPTEMBER 27, 1997

3. Tima of Death: 0530 A.M.

4a. Facility Nema *(If not institution, giva street end number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-48-9743

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: MAY 19,1948

9. Birthplece *(Stete or Foraign Country)*: MARYLAND

Usuel Rasidance of Decedent

10e. Stete: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 20201 MERRIMAN STREET

10f. Zip Code: 21532

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaer or Dates:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Educetion *(Specify only highast grede completad)*: Elamentary/Secondary (0-12): 12 / Collega (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CO-OWNER AUTO SALES

16b. Kind of Businass/Industry: AUTOMOBILE

17. Father's Neme *(First, Middle, Last)*: RAYMOND THRASHER

18. Mother's Name *(First, Middle, Maidan Surneme)*: CHRISTINE BRODIE

19e. Informent's Name/Reletionship *(Type, Print)*: JAMES W. BARTON HUSBAND

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 20201 MERRIMAN ST., FROSTBURG, MD 21532

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: SILBAUGH CREMATORY

Dete: OCT 1,1997

20c. Location - City or Town, Stete: UNIONTOWN, PA

21. Signature of Funeral Service Licansee: Douglas A Hafer

22. Name end Address of Facility: HAFER FROST MANSION FUNERAL HOME 58 FROST AVE., FROSTBURG, MD 21532

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or raspiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disaase or condition resulting in deeth)

a. Meningeal Lymphoma — 6 weeks

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted avents resulting in deeth) Lest

b. Lymphoma, recurrent with brain involvement — 1 year

Due to (or as a consequanca of):

c.

Due to (or as a consequance of):

d. Hx of Lymphoma — 715 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHF

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Strast end Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, dete end placa, and due to the cause(s) end menner es steted. 2☐ **Medtcal Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: John Mehanna M.D.

29c. License number: D-17526

29d. Dete signed *(Month, Dey, Year)*: September 27, 1997

30. Neme and address of person who completed cause of deeth (Item 28a) (Type, Print): JOHN MEHANNA, M.D. 909-B SETON DRIVE CUMBERLAND, MD. 21502

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4 yrs

State Registrar

31. Dete filed *(Month, Day, Yaer)*: SEP 30 1997

32. Registrar's Signature: Julie Dawn Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elmer E. Bergdoll

2. Date of Death Month Day Year: SEPTEMBER 27, 1997

3. Time of Death: 11:45P.M.

4a. Facility Name (If not institution, give street and number): Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-32-4158

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar 29, 1936

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. Stete: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 12015 Vernon Street

10f. Zip Code: 21502

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - American Indien, Bleck, White, etc. Specify: white

15. Decadent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Construction Worker

16b. Kind of Business/Industry: Construction

17. Fethar's Name (First, Middle, Last): Freeman A. Bergdoll

18. Mother's Name (First, Middle, Maidan Surnama): Nellie P. (Conrad)

19a. Informant's Neme/Reletionship (Type, Print): Mary Twigg-companion

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12015 Vernon Street Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Pleca of Disposition (Name of cemetery, crematory or other place): Sunset Memorial Park

Date: 09/30

20c. Location - City or Town, State: Cumberland MD

21. Signature of Funaral Service Licensee: James J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home Cumberland MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Acute myocardial infarction — 36 hours

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause givan in Part I.: Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings aveileble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and pleca, and due to the cause(s) and manner as steted. 2☐ **Medical Exeminer:** On the besis of exemination and/or Investigetion, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: [signature]

29c. License number: D 36766

29d. Dete signed (Month, Day, Year): Sept 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Vik Poonai, 955 Frederick Street, Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): SEP 3 0 1997

32. Registrar's Signature: Julia A. Nuckles-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ELMER BERGDOLL

5 TNS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31278

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Emma Banks

2. Data of Death: Month Oct Dey 5 Yaer 1997

3. Time of Death: 3:45 PM

4a. Facility Neme (If not institution, giva street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Deeth: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 219-14-4894

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Deys | If Undar 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Year): July 03, 1905

9. Birthpleca (State or Foreign Country): Talbot

Usual Residence of Decedent

10e. Stete: MD

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☑ Yas 2☐ No

10e. Street end Number: Rt. 50 + Dutchmans Lane

10f. Zip Code: 21601

10g. Citizen of Whet Country? USA

11. Maritel Status: 1☐ Naver Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar In U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grade completed): Elemantery/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Businass/Industry: Private Family

17. Fether's Neme (First, Middle, Last): Issiah Freeman

18. Mother's Nema (First, Middle, Malden Sumema): Annie Wilson

19a. Informent's Neme/Relationship (Type, Print): William H. Banks (son)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4821 Old Trappe Road - Trappe, Maryland 21673

20e. Method of Disposition: 1☒ Buriet 2☐ Crametion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Paradise Cemetery

Dete: Oct. 10, 1997

20c. Locetion - City or Town, State: Trappe, Maryland

21. Signatura of Funerel Service Licensee: Jozelle C. Henry

22. Nama and Address of Facility: Henry Funeral Home 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset end Deeth
Immediete Ceuse (Finel diseesa or condition resulting in deeth) e.	uramitoni	weeks
Due to (or es e consequence of):		
Sequentiellty tist conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last b.	chronic progressive dementia	year
Due to (or es e consequence of):		
c.	arteriosclerosis	years
Due to (or es e consequence of):		
d.		

Pert II. **Othar significant conditions** contributing to death but not rasulting in the underlying cause given in Pert I.: severe arthritis, chronic anemia

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer) | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. 2☐ **Medicel Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted.

29b. Signature end title of certifier:

29c. License number: D25750

29d. Dete signed (Month, Dey, Year): 10-6-97

30. Neme end eddress of parson who completed cause of deeth (Item 23e) (Type, Print): Robert B. Sanchez MD 508 Idlewild Ave Easton MD 21601

State Registrar

31. Dete filed (Month, Dey, Year): OCT - 9 1997

32. Registrar's Signeture: Julia Dawkins Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31279

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aurelio Crisafulli

2. Date of Death Month: Oct Day: 5, Year: 1997

3. Time of Death: 9:00PM

4a. Facility Name *(If not institution, give street and number)*: 3408 Bonita Street

4b. City, Town, or Location of Death: Suitland

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-18-4997

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 4,1915

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3408 Bonita Street

10f. Zip Code: 20746

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1944

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th; College (1-4or 5+): --

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Barber

16b. Kind of Business/Industry: Barber Shop

17. Father's Name *(First, Middle, Last)*: Anthony Crisafulli

18. Mother's Name *(First, Middle, Maiden Surname)*: Dominica DiPietro

19a. Informant's Name/Relationship *(Type, Print)*: (Wife) Veronica Crisafulli

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3408 Bonita Street Suitland, Maryland 20746

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland State Veterans Cem. Date: Oct. 9, 1997

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Lee A. Hott

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

Physician /Medical Examiner

23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Astrocytoma — 3 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William J. Oetgen M.D.

29c. License number: D-16129

29d. Date signed *(Month, Day, Year)*: 10/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William J. Oetgen M.D. 9131 Piscataway Rd.#600 Clinton, Md. 20735

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 07 1997

32. Registrar's Signature: Felicia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31280

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Michael James Carroll, JR

2. Data of Death Month Day Yaer: September 22 1997

3. Tima of Death: 10:48 AM

4a. Facility Nama *(If not institution, giva streat and number)*: Annapolis Nursing and Rehab Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 578-14-6187

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Yaar)*: April 21 1904

9. Birthplaca *(Stata or Foreign Country)*: Georgia

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Insida City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 1738 W. Winchester Rd.

10f. Zip Coda: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar In U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* white

15. Decedant's Education *(Specify only highast grade complatad)*: Elamantary/Secondary (0-12): Collaga (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Foriegn Service

16b. Kind of Busineas/Industry: Civil Service

17. Father's Nema *(First, Middla, Last)*: Michael J. Carroll

18. Mother's Neme *(First, Middle, Maidan Surnema)*: Rose Long

19a. Informant's Name/Ralationship *(Type, Print)*: Estelle Carroll/ Wife

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1738 W. Winchester Rd. Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Hillcrest Memorial Gardens

Data: 09/25/97

20c. Location - City or Town, Stata: Annapolis, MD

21. Signature of Funeral Service Licensee: D Rolland

22. Nama and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused the daath. Do not entar the mode of dying, such es cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disease or condition resulting in daath)

e. Renal Failure — 2 weeks

Due to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last

b. advanced age

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.: Demented

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case rafarred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☒ Nursing Home 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Data of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, dete end placa, and dua to the ceusa(s) and mennar stated.

29b. Signature and title of cartifier: R Hochman MD

29c. License number: D05192

29d. Date signed *(Month, Day, Yaar)*: 9/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard I. Hochman, MD. 1833A Forest Dr. Annapolis, Maryland 21401

State Registrar

31. Data filad *(Month, Day, Yaar)*: SEP 23 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31281

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FIORIGIA COLAVINCENZO
2. Date of Death Month: SEPTEMBER Dey: 14 Year: 97
3. Time of Death: 9:15 PM
4a. Facility Name (If not institution, give street and number): Brooke Grove Nursing Home
4b. City, Town, or Location of Death: Sandy Spring
4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 191-05-3165
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): October 9,1908
9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery County
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4609 Hornbean Drive
10f. Zip Code: 20853
10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Severino DiGirolomo
18. Mother's Name (First, Middle, Maiden Surname): Antonietta DiGregorio

19a. Informant's Name/Relationship (Type, Print): Elda Winslow /Dtr
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4609 Hornbean Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Saint Agatha Cemetery
Date: September 16, 1997
20c. Location - City or Town, State: Ellwood City Pennsylvania

21. Signature of Funeral Service Licensee: Helen W. Tomon
22. Name and Address of Facility: Joseph A. Tomon, Jr. Funeral Home 16117
123 5th Street, P.O. Box 188, Ellwood City, PA

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory erresf, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. GASTRO INTESTINAL HEMORRHAGE — 5 HOURS.

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading fo immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deafh) Last

b. Due to (or as e consequenca of):

c. Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ADVANCED ALZHEIMER'S DEMENTIA

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, sfreet, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at fhe time, date and place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: T Howe MD
29c. License number: D33700
29d. Date signed (Month, Day, Year): SEPTEMBER 15, 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): TED HOWE. 7542 OVERLOOK DR. BOONSBORO, MD 21713

State Registrar

31. Dete filed (Month, Day, Year): SEP 26 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Ammended Harford County Health Dept. 10/1/97 Line 23B KDG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31282

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ENOCH EMANNUAL CUBBAGE

2. Date of Death (Month, Day, Year): September 21, 1997

3. Time of Death: 4:30 PM

4a. Facility Name *(If not institution, give street and number)*: 504 Catalpa Lane

4b. City, Town, or Location of Death: Edgewood

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-30-2312

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: April 1, 1927

9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedant

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 504 Catalpa Lane

10f. Zip Coda: 21040

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No. If Yas, Giva Yaar or Datas: Unknown

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 9; Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Production Line Worker

16b. Kind of Businass/Industry: Can Manufacturing

17. Fathar's Nama *(First, Middla, Laida Surnama)*: David Enoch Cubbage

18. Mother's Nama *(First, Middla, Maidan Surnama)*: Manda (nmn) Judy

19a. Informant's Name/Ralationship *(Type, Print)*: Carmelita J. Cubbage - Wife

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 504 Catalpa Lane, Edgewood, MD 21040

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Harford Memorial Gardens

Data: 9-24-97

20c. Location - City or Town, Stata: Aldino, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emge

22. Nama and Addrass of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Between Onset and Death

Immediate Causa (Finel disaasa or condition rasulting in daath)
a. RESPIRATORY FAILURE — MINUTES

Due to (or as a consequence of):
b. ADENOCARCINOMA of the Lung — 1 year

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Last

Due to (or as a consequance of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.: ESSENTIAL HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☑ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☑ Rasidance 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Barry Wohl MD

29c. License number: D22097

29d. Data signed *(Month, Day, Year)*: SEPTEMBER 22, 1997

30. Name and addrass of person who completed causa of daath (Item 23a) (Type, Print): BARRY WOHL M.D. 615 W. MACPHAIL RD SUITE 206 BEL AIR MARYLAND 21014

State Registrar

31. Data filed *(Month, Day, Year)*: SEP 24 1997

32. Registrar's Signature: Linda Sanders Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31283

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CORA C. COGAN

2. Date of Death Month / Day / Year: September 25 1997

3. Time of Death: 1:50 PM

4a. Facility Name *(if not institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: HArford

Funeral Director

5. Social Security Number: 215-10-4726

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6/18/03

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 200 C. Timber Trail

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cashier

16b. Kind of Business/Industry: Hotel

17. Father's Name *(First, Middle, Last)*: Fred nelson Ramsay

18. Mother's Name *(First, Middle, Maiden Surname)*: Corine Mary Minnich

19a. Informant's Name/Relationship *(Type, Print)*: Merle McElwain

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: RR2, Box 4450, Felton, PA 17322

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Mary's Cemetery

Date: 9/29/97

20c. Location - City or Town, State: Pylesville, MD

21. Signature of Funeral Service Licensee: Jeffrey P. Lovelidge

22. Name and Address of Facility: Harkins F.H.Inc.,600 MainSt.,Delta,PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Stroke — Approximate Interval: 3days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection

Renal Failure

Ileus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Willard P. Amoss

29c. License number: D 04354

29d. Date signed *(Month, Day, Year)*: September 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Willard P. Amoss 2303 Belair Road, Fallston MD 21047

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Lisa Andrea Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Cora Cogan

12

WRC
97-5354-015
HOBERT E. COX

Items: 23, part 1, 27, 28a, b, c, d, e, f, per MEO, bam 10/7/97

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hobert E. Cox
2. Date of Death (Month, Day, Year): SEPT. 17, 1997
3. Time of Death: 9:25 PM.
4a. Facility Name (If not institution, give street and number): MARYLAND MANOR MOTEL
4b. City, Town, or Location of Death: ELKTON
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 213-94-4454
6. Sex: X 1 M 2 F
7. Age (In yrs. last birthday): 30 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 29, 1966
9. Birthplace (State or Foreign Country): Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: X 1 Yes 2 No
10e. Street and Number: 1375 Nottingham Road
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Handyman
16b. Kind of Business/Industry: General

17. Father's Name (First, Middle, Last): Ernest H. Cox
18. Mother's Name (First, Middle, Meiden Surname): Dorothy Faye Leake

19a. Informant's Name/Relationship (Type, Print): Ernest H. Cox, Father
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 118 Hannum Dr, Bear, De. 19701

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): West Nottingham Cemetery | Dete: 9/22/97
20c. Location - City or Town, State: Rising Sun, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name end Address of Facility: 259 E. Main St., Gee Funeral Home Elkton, Md. 21921

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on eech line. | Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth): e. Narcotic Intoxication
Due to (or as a consequence of):
Sequentiellty list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest:
b. Due to (or as e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cauae of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Wes en eutopsy performed? 1 X Yes 2 No
24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1 X Yes 2 No

25. Was case referred to medical examiner? X Yes 2 No
26. Place of Deeth (Check only one): Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA | Other: 4 Nursing Home 5 Residence 8 X Other (Specify) MOTEL

27. Menner of Deeth: 1 Netural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined
28a. Dete of Injury (Month, Dey Yeer): 9/17/97
28b. Time of Injury: 9:10 p M found
28c. Injury at Work? 1 Yes 2 X No
28d. Describe how injury occurred: subject ingested drugs
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): unknown
28f. Location (Street and Number or Rurel Route Number, City or Town, State): unknown

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, end due to the ceuse(s) end menner as stated. 2 X Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated.
29b. Signature and title of certifier: Stephen S. Radentz, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Year): SEPT. 18, 1997
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): SEP 29 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31285

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM ALTON CHAMBERLAIN, JR.

2. Date of Death (Month, Day, Year): SEPTEMBER 30, 1997

3. Time of Death: 2213

4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 206 01 7595

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 23, 1903

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: 100 HONEYSUCKLE LANE

10f. Zip Code: 21532

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRIEST

16b. Kind of Business/Industry: CHURCH

17. Father's Name (First, Middle, Last): WILLIAM ALTON CHAMBERLAIN, SR.

18. Mother's Name (First, Middle, Maiden Surname): BERTHA MAY KAHLERT

19a. Informant's Name/Relationship (Type, Print): KATHERINE CHAMBERLAIN / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 HONEYSUCKLE LANE, FROSTBURG, MD 21532

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): THE CUMBERLAND CREMATORY

Date: 10/1/97

20c. Location - City or Town, State: CUMBERLAND, MD 21502

21. Signature of Funeral Service Licensee: Marilou M. Sowers

22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Congestive heart Failure	1 Week
Due to (or as a consequence of):	b. Ischemic Cardiomyopathy	5 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. Atherosclerosis	50 years
Due to (or as a consequence of):	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure.

old age

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S L Sandhir MD

29c. License number: D14464

29d. Date signed (Month, Day, Year): October 01 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sikander Sandhir M.D. 48 Tara Terrace Frostburg MD 21532

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Julia Thurston-Hardesty

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3 MS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELLEN CHEW

2. Deta of Deeth: Month September Dey 25, Yeer 1997

3. Time of Death: 7:05 A.M.

4a. Facility Name (If not institution, give street and number): Home- 319 N. First Street

4b. City, Town, or Location of Deeth: Crisfield

4c. County of Deeth: Somerset

Funeral Director

5. Social Security Number: 277-36-2506

6. Sax: 1☐ M 2☒ F

7. Age (In yrs. lest birthday): 56 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Dec. 19, 1940

9. Birthpleca (Stete or Foraign Country): Maryland

Usuel Residence of Decedant

10a. Stete: Maryland

10b. County: Somerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 319 N. First Street

10f. Zip Code: 21817

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completad)

Elementery/Secondary (0-12): 12 Years

College (1-4or 5+): 3 Years

16e. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired): Practical Nurse

16b. Kind of Business/Industry: Medical

17. Fethar's Neme (First, Middle, Last): William B. Ford

18. Mother's Name (First, Middle, Maiden Sumame): Ellen K. Knox

19e. Informent's Name/Relationship (Type, Print): Monroe G. Chew, 4th- Husband

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda): 319 N. First St. - Crisfield, MD 21817

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Spacify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Salisbury Crematory

Dete: 9/26/97

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.

22. Name end Address of Feciility: Bradshaw & Sons Funeral Home, 306 W. Main St.- Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth) e. ASCVD — Acute

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immedieta cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

b. Due to (or as a consequence of):

c. Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was cese referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Deeth (Check only one) Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Piace of Injury - At home, farm, street, factory, office building, etc. (Spacify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifiar (Check only one) 1☐ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner statad.

29b. Signatura and titla of certifier: M. D. Barhan

29c. License number: 12764

29d. Date signed (Month, Dey, Yeer): Sept. 25, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Madhav D. Barhan, M.D. - 4384 Crisfield Highway - Crisfield, MD 21817

State Registrar

31. Dete filed (Month, Dey, Yeer): SEP 30 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rav 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

WRC
97-5682-003
HELEN M.
DWYER
Item:7 per FH G-753 11/3/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31287
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Marie Dwyer
2. Date of Death Month Day Yeer: OCT. 05, 1997
3. Time of Death: 8:30 AM
4e. Facility Name (If not institution, give street and number): 648 ALABAMA AVE.
4b. City, Town, or Location of Death: ROSE HAVEN
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-80-9372
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 37 ~~59~~ Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): OCT. 8,1959
9. Birthplace (State or Foreign Country): Illinois

Usuet Residenca of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Rose Haven
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 648 Alabama Avenue
10f. Zip Code: 20714
10g. Citizen of What Country? U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decadant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Cashier
16b. Kind of Business/Industry: Super Market/Grocery

17. Fether's Nema (First, Middle, Last): Norman Leroy Hancock
18. Mother's Nema (First, Middle, Maiden Surnama): Mary Helen Dawson

19e. Informant's Name/Reletionship (Type, Print): Steven J. Dwyer/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 648 Alabama Ave. Rose Haven, Maryland 20714

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Lee Crematory
OCT. 9,1997
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Sarvica Licansee: Joseph Bart Sr
22. Neme end Address of Facility: Lee Funeral Home Calvert,P.A. 8125 So. Md. Blvd. Owings, Maryland 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. (Approximate Intervel Between Onset end Deeth)

Immediate Cause (Finat diseese or condition resulting in death): e. Atherosclerotic Cardiovascular Disease
Due to (or es e consequence of):
Sequentiellty tist conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disaasa or Injury that initieted events resulting in death) Lest:
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? ~~1☒~~ Yes 2☐ No
24b. Were eutopsy findings evellable prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) and manner es stated. ☒ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, deta and plece, and due to the ceuse(s) and menner stated.
29b. Signeture end title of certifier: Dennis J. Chute MD
29c. Licansa number: O.C.M.E.
29d. Date signed (Month, Dey, Yeer): OCT. 06, 1997
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Yeer): OCT 0 7 1997
32. Registrer's Signetura: Julie Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

97-5406-003
ML

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

PATRICIA JOAN DUGAN PIGOTT

Certificate of Death

Reg. No. 97 31288

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Patricia Joan Dugan-Pigott

2. Data of Deeth Month / Day / Year: SEPTEMBER 21 1997

3. Tima of Daath: 2:12 AM

4e. Facility Neme *(If not institution, give street end number)*: MD.RTE.50 EASTBOUND

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Deeth: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 424-64-8588

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Year)*: March 11,1948

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residanca of Decedant

10e. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1010 Rosslare Court

10f. Zip Code: 21012

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Naver Married 2☒ Marriad 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12+ / College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa ratired)*: Classified Administrative Asst. White House

16b. Kind of Business/Industry: U.S. Government

17. Father's Nema *(First, Middle, Last)*: Francis Xavier Dugan

18. Mother's Nama *(First, Middle, Meidan Surnama)*: Margaret B. Fieldsburns

19a. Informent's Neme/Relationship *(Type, Print)*: George A. Pigott, Jr./husband

19b. Mailing Addrass *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1010 Rosslare Court, Arnold, MD 21012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, cremetory or other piece)*: MD Veterans Cemetery

Dete: Sept 24 1997

20c. Location - City or Town, Steta: Crownsville, MD

21. Signature of Funeral Service Licansee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

24a. (Part I) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Causa (Finat disease or condition resulting in death): a. Multiple Injuries

Dua to (or as a consaquance of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events rasulting in death) Last: b.

Dua to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings availeble prior to completion of causa of deeth? 1☒ Yes 2☐ No

25. Was case referred to medicat exeminar? 1☒ Yes 2☐ No

26. Placa of Daath *(Check only ona)*: Hospitel: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Mannar of Deeth: 1☐ Naturel 2☒ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Deta of Injury *(Month, Dey Year)*: 9-21-97

28b. Time of Injury: 0212 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Automobile accident

28e. Pleca of Injury - At hama, farm, street, factory, office building, etc. *(Specify)*: Street

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: Route 50 East Arnold, Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha time, date end plece, end due to the causa(s) end manner as stated. 2☒ **Medical Examiner:** On tha basis of examinetion end/or investigation, in my opinion, daath occurrad at tha time, data and placa, and due to the causa(s) end menner stetad.

29b. Signatura end title of certifier: Stephen S. Radentz

29c. Licensa number: O.C.M.E.

29d. Date signed *(Month, Dey, Year)*: SEPTEMBER 22,1997

30. Nama end address of person who completed cause of deeth (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Dey, Year)*: SEP 25 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Ammended Harford County Health Dept. Line # 19a 10/03/97

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31289

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HANNAH ROBERTA DORSEY

2. Date of Death: Month OCTOBER Day 1 Year 1997

3. Time of Death: 0635

4a. Facility Name (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: HAVRE de GRACE

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-30-2287

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 16 1911

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: HARFORD

10c. City, Town or Location: ABERDEEN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 601 CORNELL STREET APT. 113

10f. Zip Code: 21001

10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+): —

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOUSEKEEPER DOMESTIC

17. Father's Name (First, Middle, Last): GEORGE NELSON DORSEY

18. Mother's Name (First, Middle, Maiden Surname): ANNA AMELIA CEVIS

19a. Informant's Name/Relationship (Type, Print): EARL Dorsey ~~Brother~~ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 601 CORNELL St. Apt. 113, ABERDEEN, MD 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): BEAKLEY CEM.

Date: 10/4/97

20c. Location - City or Town, State: DARLINGTON, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: BEARD FUNERAL HOME 552 LEWIS Street, HAVRE de GRACE, MD.

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary artery disease — 73 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last:

b.

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Patient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 028334

29d. Date signed (Month, Day, Year): October 1 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CINDA FREILICH 111 Chanel Road Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): OCT 2 1997

32. Registrar's Signature: [signature] Barbara Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31290

LERLEAN DUNCAN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lerlean Duncan

2. Date of Death: Month Sept. Day 28 Year 1997

3. Time of Death: 12:22 a

4a. Facility Name (If not institution, give street and number): The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 429-56-2658

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08/15/09

9. Birthplace (State or Foreign Country): Ark.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 522 Gay Street

10f. Zip Code: 21629

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 3rd

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife

16b. Kind of Business/Industry: Home Engineer

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Neme/Relationship (Type, Print): Anna Bell Ashley (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 522 Gay Street, Denton, Maryland 21629

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crematory Capital

Dete: 10/8/97

20c. Location - City or Town, State: Dover, Delaware

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

e. PROFOUND ANEMIA — 1 YEAR

Due to (or es a consequence of):

b. HEMORRAGE — IMMEDIATE

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last

Due to (or as e consequence of):

c. CARCINOMA RECTUM — 2 YEARS

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA STOMACH

23b. **Did tobacco uee contribute to the cauee of death?** 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C.W. Bain DD

29c. License number: D00250

29d. Date signed (Month, Dey, Year): 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Callum Bain, M D ,415 B East Dover St., Easton, Maryland 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires thet the death certificete be executed within 24 hours efter deeth.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

State Registrar

31. Date filed (Month, Day, Year): OCT 0 3 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31291

Certificate of Death

Reg. No.

Dutton, James M

2442

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James O. Dutton
2. Date of Death Month: 09 Day: 27 Year: 97
3. Time of Death: 03:40
4a. Facility Name *(If not institution, give street and number)*: Dorchester General Hospital, 300 Bryn St.
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-01-9191
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02/05/15
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 520 Glenburn Ave.
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Manufactoring

17. Father's Name *(First, Middle, Last)*: John Dutton
18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Mildred George (friend)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 833 Fairmont Ave., Cambridge, Maryland 21613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bethel Cemetery — Date: 10/3/97
20c. Location - City or Town, State: Cambridge, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bennie smith funeral Home P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Urosepsis	5 Days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple Myeloma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 47924
29d. Date signed *(Month, Day, Year)*: 09 27 97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): NOMAN THANEY 10 AURORA ST. CAMBRIDGE MD 21613

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997
32. Registrar's Signature: [signature] Lisa Davidson-Tyndale

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PRESTON T. DAVIS
2. Date of Death (Month, Day, Year): OCTOBER 4, 1997
3. Time of Death: 1000
4a. Facility Name (If not institution, give street and number): 109 SOMERSET STREET
4b. City, Town, or Location of Death: OCEAN CITY
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 217-01-4356
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3-6-07
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 109 SOMERSET STREET
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BARBER
16b. Kind of Business/Industry: SERVICES

17. Father's Name (First, Middle, Last): ARCHIE ERNEST DAVIS
18. Mother's Name (First, Middle, Maiden Surname): ALICE E. JARVIS

19a. Informant's Name/Relationship (Type, Print): DEAN DAVIS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10359 KEYSER POINT RD., OCEAN CITY, MD., 21842

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): EVERGREEN CEMETERY | Date: 10-8
20c. Location - City or Town, State: BERLIN, MARYLAND

21. Signature of Funeral Service Licensee: John S. Ullrich
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD., 21811

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ **Yes** 2 ☐ **No** 3 ☐ **Probably** 4 ☒ **Unknown**

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D46257
29d. Date signed (Month, Day, Year): 10/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): E. CASTANEDA, MD 306 FRANKLIN AVE BERLIN MD 21811

State Registrar

31. Date filed (Month, Day, Year): OCT 06 1997
32. Registrar's Signature: Julia Davidson-Randell

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31293

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Bruce Deatelhauser

2. Date of Death Month Day Year: Sep 27, 1997

3. Time of Death: 1900

4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-38-5735

6. Sex: 1☐M 2☐F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 16, 1940

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☐Yes 2☐No

10e. Street and Number: 901 Harding Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☐No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Merchandiser

16b. Kind of Business/Industry: PIMMS

17. Father's Name *(First, Middle, Last)*: William E. Deatelhauser

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy V. (Baker)

19a. Interment's Name/Relationship *(Type, Print)*: Barbara Deatelhauser-wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 901 Harding Avenue Cumberland MD 21502

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Memorial Park

Date: 10/01

20c. Location - City or Town, State: Cumberland MD

21. Signature of Funeral Service Licensee: James F Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home Cumberland MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock — 4 hours

Due to (or as a consequence of):

b. Acute Myocardial infarct

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. AS HD - Coronary disease

Due to (or as a consequence of):

d. Status post coronary By Pass — 9 years ago

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hx of Cancer of left Parotid

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☐No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☐No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Mehanna M.D

29c. License number: D 17526

29d. Date signed *(Month, Day, Year)*: September 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Mehanna M.D. 909-B Seton Drive Cumberland MD 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

12 MS

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 30 1997

32. Registrar's Signature: Julia Marshall-Randall

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31294

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLARICE LEE DAUM
2. Date of Death (Month, Day, Year): October 4, 1997
3. Time of Death: 11:45 pm
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-24-0382
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 20 1928
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 628 FREDERICK STREET
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTS PAYABLE DEPT.
16b. Kind of Business/Industry: KELLY SPRINGFIELD TIRE

17. Father's Name (First, Middle, Last): RUSSELL V. WARNICK
18. Mother's Name (First, Middle, Maiden Surname): SYLVIA E. WILKINS

19a. Informant's Name/Relationship (Type, Print): CHARLES T. DAUM HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 628 FREDERICK STREET CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ROCKY GAP VET CEMETERY
Date: OCTOBER 7 1997
20c. Location - City or Town, State: RFD FLINTSTONE MD.

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Advanced Metastatic Non-Small Cell Carcinoma of Lung. — Two Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Qamar MD
29c. License number: D 23371
29d. Date signed (Month, Day, Year): October 6 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Qamar Zaman-Johnson Heights Medical Building-Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year): OCT 07 1997
32. Registrar's Signature: John Thurston-Kendall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6
718

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WANDA MARY ELLIOTT

2. Date of Death (Month, Dey, Year): October 1, 1997

3. Time of Death: 10:40pm

4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-12-9384

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): March 3, 1910

9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 379 South Drive

10f. Zip Code: 21001

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind ot Business/Industry: Own Home

17. Father's Neme (First, Middle, Last): John Blaine Hinks

18. Mother's Neme (First, Middle, Maiden Surneme): Jeanette Josephine Goyette

19a. Interment's Name/Reletionship (Type, Print): William H. Smullen - nephew

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 379 South Drive, Aberdeen, MD 21001

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☒ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece ot Disposition (Neme of cemetery, cremetory or other piece): Caretakers Bluemont Cem.

Dete: 10-4-97

20c. Location - City or Town, Stete: Grafton, W. Virginia

21. Signeture of Funeral Service Licensee: Stephen A Mehugh

22. Neme end Address of Facility: Howard K. McComas III Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart tailure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death)

e. RESPIRATORY FAILURE — 2 days

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. PNEMONIA.

Due to (or es e consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or es e consequence ot):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

CHRONIC ATRIXL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion ot ceuse of death? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece ot Death (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time ot Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, tactory, office building, etc. (Specify)

28t. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certitier (Check only one): 1☑ Certifying Physician: To the best ot my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. 2☐ Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Manuel M. Lazaton MD

29c. License number: D15583

29d. Dete signed (Month, Dey, Yeer): October 2, 1997

30. Neme end eddress ot person who completed ceuse ot deeth (Item 23a) (Type, Print): MANUEL M. LAZATON MD 8 Law Street Aberdeen, Maryland 21001

State Registrar

31. Dete filed (Month, Day, Year): OCT 3 1997

32. Registrar's Signature: Linda Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

2240 10/1/97

ELLIOTT, Wanda Mary

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31296

Charles Evans SS# 220-10-9820

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: CHARLES WASHINGTON EVANS

2. Date of Death Month / Dey / Yeer: October 2, 1997

3. Time of Death: 1235

4e. Facility Neme *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Deeth: WICOMICO

5. Social Security Number: 220-10-9820

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5/16/18

9. Birthplece *(State or Foreign Country)*: MD

Usuel Residenca of Decedent

10a. Stete: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 1019 Margaret St.

10f. Zip Code: 21801

10g. Citizen of Whet Country?: USA

11. Meritei Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 3 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Sand & Gravel Business

17. Fether's Neme *(First, Middle, Last)*: C.W. Evans, Sr.

18. Mother's Neme *(First, Middle, Maiden Surname)*: Sara Eva Jones

19a. Informent's Neme/Reletionship *(Type, Print)*: Irma Jean Evans

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1019 Margaret St. Salisbury, MD 21801

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, cremetory or other place)*: Riverside Cemetery

Dete: 10/6/97

20c. Location - City or Town, Stete: Libertytown, MD

21. Signeture of Funeral Service Licensee: W. Fiss Burbage

22. Neme end Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in death)

e. Cardiac Arrest

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

b. Respiratory Failure

Due to (or es e consequence of):

c. Pneumonia

Due to (or es e consequenca of):

d.

Pert II. **Other elgnificant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: CHF, COPD, Sepsis, Hypotension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes an eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier: [illegible] MD

29c. License number: D0050614

29d. Date signed *(Month, Day, Year)*: 10/2/97.

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): 262 Tilghman Rd Salisbury MD 21804

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 03 1997

32. Registrer's Signeture: Julia Davidson-Randall

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Medical Certification:

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31297

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Alexander Frederick

2. Data of Death Month: SEPTEMBER Day: 19 Yaar: 1997

3. Tima of Death: 3:30 P.M.

4a. Facility Nama *(If not institution, giva street and numbar)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Numbar: 215-10-1429

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: March 25, 1916

9. Birthplace *(State or Foraign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Millersville

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 8359 Sycamore Road

10f. Zip Coda: 21108

10g. Citizen of Whet Country?: U. S. A.

11. Marital Statis: 1☐Navar Married 2☐Married 3☒Widowad 4☐Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 8; Collega (1-4or 5+): None

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Millwrite

16b. Kind of Businass/Industry: Construction

17. Fathar's Nama *(First, Middla, Last)*: John Frederick

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Ida Yoe

19a. Informant's Name/Ralationship *(Type, Print)*: Charles Semrau Frederick

19b. Mailing Address *(Streat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 703 Cotter Road Glen Burnie, Md. 21060

20a. Mathod of Disposition: 1☐Burial 2☒Cremetion 3☐Ramoval from Steta 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Name of cematery, crematory or othar placa)*: Chesapeake Crematory Inc

Data: 9/23/1997

20c. Location - City or Town, State: Beltsville, Md.

21. Signature of Funaral Service Licansea: Michael C. Soffron

22. Nama and Address of Facility: Singleton Funeral Home PA, 1 Second Avenue S.W. Glen Burnie, Md. 21061

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one causa on aach line.

Approximata Intarval Batween Onsat and Death

Immediata Cause (Finel diseesa or condition resulting in death): a. ENCEPHALOPATHY

Due to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disaase or injury that initiated events resulting in daath) Last:

b. Due to (or as a consaquance of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☑Yas 2☐No

24b. Ware autopsy findings availabla prior to compiation of causa of death? 1☐Yes 2☑No

25. Wes casa rafarred to madical exeminar? 1☐Yas 2☑No

28. Placa of Death *(Check only one)*: Hospitel: 1☑Inpatiant 2☐ER/Outpatient 3☐DOA Othar: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding investigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how Injury occurred

28e. Plece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)*: 1☑**Certifying Physician:** To tha bast of my knowladga, daath occurrad at tha time, data and place, and dua to tha cause(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha time, dete and piece, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifier: Jeffrey Hoffman

29c. License number: D43977

29d. Date signed *(Month, Day, Year)*: SEPTEMBER 19 1997

30. Name and eddrass of person who completed causa of death (Item 23a) (Type, Print): Cynthia Greenwood, 301 Hospital Drive, Glen Burnie, MD, 2061.

State Registrar

31. Data filad *(Month, Day, Year)*: SEP 23 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

CHARLES FREDERICK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31298

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JULIAN HENRY LEE FISHER

2. Date of Death Month / Day / Year: OCTOBER 6, 1997

3. Time of Death: 0650

4e. Facility Name *(If not institution, give street end number)*: BERLIN NURSING & REHAB. CTR.

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 123-09-9880

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8-4-01

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: WORCESTER

10c. City, Town or Location: OCEAN CITY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 10143 SILVER POINT LANE

10f. Zip Code: 21842

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | Collega (1-4or 5+):

18a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: REALTOR

16b. Kind of Businass/Industry: REAL ESTATE

17. Father's Name *(First, Middle, Last)*: EDWARD Mc. FISHER

18. Mother's Name *(First, Middle, Meiden Surneme)*: GULIELMA POULTNEY LEE

19a. Informant's Name/Relationship *(Type, Print)*: ANNE C. HALL

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14 BAYBERRY LANE SELBYVILLE, DEL., 19975

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: SALISBURY CREMATORY

Date: 10-7

20c. Location - City or Town, State: SALISBURY, MD.

21. Signature of Funeral Service Licensee: John A. Ullrich

22. Name end Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD., 21811

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart failure. List only one ceuse *on* each line.

Approximete Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to Immadiete ceuse. Enter Underlying Cause (Disaese or Injury thet initiated events resulting in death) Lest

b. CEREBROVASCULAR DISEASE

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residance 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to tha ceusa(s) and mennar stated.

29b. Signature and title of certifier: Edward Castaneda MD

29c. License number: D46257

29d. Date signed *(Month, Dey, Year)*: 10/6/97

30. Neme end address of person who complatad ceuse of death (Item 23a) (Type, Print): E. CASTANEDA, MD 306 FRANKLIN AVE BERLIN, MD 21811

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Day, Yeer)*: OCT 06 1997

32. Registrer's Signetura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31299

CARMEN E. FULLER

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carmen Earl Fuller

2. Data of Death Month Day Yaar: SEPTEMBER 18 1997

3. Tima of Death: 11:40 pm

4a. Facility Nama (If not institution, giva street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 133-34-6245

6. Sax: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 54 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): May 12, 1943

9. Birthplace (State or Foraign Country): Pennsylvania

Usual Residence of Decedant

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Numbar: 600 Hamilton Place

10f. Zip Coda: 21061

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Navar Marriad 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Dacedant's Education (Specify only highast grada complatad)

Elamantary/Secondary (0-12): 12

Collega (1-4or 5+): 2

18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Salesman

16b. Kind of Businass/Industry: Printing / Graphics

17. Fathar's Nama (First, Middla, Last): Carmen Wilson Fuller

18. Mothar's Nama (First, Middla, Maidan Surnama): Marion Andrews

19a. Informant's Nama/Ralationship (Type, Print): Mary Margaret Fuller

19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 600 Hamilton Place Glen Burnie, Md. 21061

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): Meadowridge Memorial Park

Data: 9/22/1997

20c. Location - City or Town, Stata: Elkridge, Md.

21. Signature of Funaral Sarvica Licensaa: Michael C. Saffian

22. Nama and Addrass of Facility: Singleton Funeral Home PA, 1 Second Avenue S.W. Glen Burnie, Md 21061

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata intarval Batwaen Onsai and Death:

Immediata Cause (Finel disaasa or condition rasulting in daath)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequenca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Disaasa or Injury thet initiated evants rasulting in death) Last

b. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

c. ATHEROSCLEROTIC CORONARY ARTERY DISEASE

Due to (or as a consaquanca of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

ANKYLOSING SPONDYLITIS.
HYPERTENSION

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [■] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [■] No

24b. Wara autopsy findings available prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was casa rafarrad to medical exeminar? 1 [ ] Yas 2 [■] No

28. Plece of Deeth (Check only ona)

Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [■] DOA

Othar: 4 [ ] Nursing Hema 5 [ ] Rasidanca 6 [ ] Othar (Specify)

27. Mannar of Daath: 1 [■] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be determined

28a. Deta of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [■] **Certifying Physician:** To the best of my knowledge, deeth occurred at tha time, deta and place, and due to the ceuse(s) end mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of exeminetion and/or investigation, in my opinion, daath occurred at the time, data and placa, and due to the ceusa(s) and mannar stated.

29b. Signature and title of certifier: David Rose, M.D.

29c. Licansa number: D19891

29d. Data signed (Month, Day, Year): 9/19/97

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): DAVID ROSE, MD SUITE SW 200 HOSPITAL GLEN BURNIE MARYLAND 21061

State Registrar

31. Data filed (Month, Day, Year): SEP 23 1997

32. Ragistrar's Signatura: Julia Davidson Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtle L. Ford
2. Date of Death (Month, Day, Year): September 25, 1997
3. Time of Death: 8:00 a.m.
4a. Facility Name (If not institution, give street and number): Edw.W.McCready Memorial Hospital
4b. City, Town, or Location of Death: Crisfield
4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 215-05-8910
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): July 18, 1909
9. Birthplace (State or Foraign Country): Maryland

Usual Residence of Decedent

10a. State: Virginia
10b. County: - - -
10c. City, Town or Location: Virginia Beach
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 4712 Fairway Avenue
10f. Zip Coda: 23462
10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): Grade 8 | Collaga (1-4or 5+): - - -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
18b. Kind of Businass/Industry: At Home

17. Fathar's Nama (First, Middle, Last): William T. Boone
18. Mothar's Name (First, Middle, Maiden Surname): Marion Abbott

19a. Informant's Name/Ralationship (Type, Print): Shirley Cullen (Daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4712 Fairway Avenue - Virginia Beach, VA 23462

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other piece): Sunnyridge Memorial Park
Date: 9/26/97
20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.
Robert H. Bradshaw, Jr.
22. Nama and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

		Approximate Interval Between Onset and Death
Immediate Causa (Final disease or condition resulting in daath) a.	Urosepsis	
Due to (or as a consequance of):		
Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disaase or Injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.: Hyponatremia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Straet end Numbar or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, end due to tha cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier
29c. License number: D48098
29d. Date signed (Month, Day, Year): Sept. 26, 1997

30. Name and address of person who complated cause of death (Item 23a) (Type, Print): Dr. Vijaykumar Karumbunathan, McCready Hospital, Crisfield, Md. 21817

State Registrar

31. Data filed (Month, Day, Yeer): SEP 30 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31301

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: James Goldsmith

2. Dete of Deeth Month / Dey / Yeer: October 4 1997

3. Time of Death: 12:45pm.

4e. Fecility Neme *(If not institution, give street end number)*: 8060 Bensville Road

4b. City, Town, or Location of Deeth: Waldorf

4c. County of Deeth: Charles

Funeral Director

5. Sociel Security Number: 215-12-3699

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Feb. 14 1919

9. Birthplece *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 8060 Bensville Rd.

10f. Zip Code: 20603

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer

16b. Kind of Business/Industry: Farming

17. Fether's Neme *(First, Middle, Last)*: James E. Goldsmith

18. Mother's Neme *(First, Middle, Melden Surneme)*: Mamie Hodges Goldsmith

19e. Informent's Name/Reletionship *(Type, Print)*: Mae Viola Goldsmith/Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 8060 Bensville Rd. Waldorf,MD 20603

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Holy Ghost Cem. Dete: 10/08/97

20c. Location - City or Town, Stete: Issue,MD

21. Signeture of Funeral Service Licensee: David C. Echols MO0945

22. Neme end Address of Fecility: AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata,MD 20646

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth) e. Lung Cancer - Metastatic

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: COPD - Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [ ] No

26. Piece of Death *(Check only one)*: Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted. 2 [ ] **Medical Examiner:** On the beeis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: Henry Burke MD

29c. License number: D01009

29d. Dete signed *(Month, Dey, Yeer)*: 10-6-97

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Henry Burke, MD La Plata, MD 20646

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 07 1997

32. Registrer's Signeture: Julia Dawkins Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION MILTON GORMAN
2. Date of Death Month Dey Year: SEPTEMBER 21, 1997
3. Time of Death: 10:02 PM
4a. Facility Name (If not institution, give street and number): 29 MARLEY NECK ROAD
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 218-26-9776
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthdey): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): AUG. 14, 1931
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 29 MARLEY NECK ROAD
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): N/A
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK MECHANIC
18b. Kind of Business/Industry: TRUCK REPAIR

17. Father's Name (First, Middle, Last): MILTON GORMAN
18. Mother's Name (First, Middle, Meiden Surname): DOROTHY VIOLA CLAPPER

19a. Informant's Neme/Relationship (Type, Print): ANN G. GORMAN (WIFE)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 29 MARLEY NECK ROAD, GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1 [X] Buriai 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): GLEN HAVEN MEMORIAL PARK
Dete: 9/24/97
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. Metastatic Poorly differentiated Carcinoma of lung — 11 Months

Due to (or as a consequence of):
b. Acute spinal cord compression — 1 month

Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest
Due to (or as a consequence of):
c. Humeral fracture left arm. — 3 weeks

Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Gayatri Nimmagadda
29c. License number: D 39041
29d. Dete signed (Month, Dey, Year): September 22nd 1997

30. Name and address of person who completed ceuse of death (item 23a) (Type, Print): GAYATRI NIMMAGADDA HARBOR HOSPITAL Center 3001 S. HANOVER Street MD. BALTIMORE

State Registrar

31. Date filed (Month, Dey, Year): SEP 23 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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AMEND # 5 cms 10/8/97 AACO Health

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31303

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carl W. H. Ganz

2. Date of Death (Month, Day, Year): September 16 1997

3. Time of Death: 9:02PM

4a. Facility Name (If not institution, give street and number): Annapolitan Assisted Living

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: ~~213-03-2660~~ 213-30-2660

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 01 1900

9. Birthplace (State or Foreign Country): Baltimore

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☑ No

10e. Street and Number: 84 North Old Mill Bottom Road

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager/ National Advertising

16b. Kind of Business/Industry: Baltimore Sun

17. Father's Name (First, Middle, Last): Ernest Ganz

18. Mother's Name (First, Middle, Maiden Surname): Fredricka Schmidt

19a. Informant's Name/Relationship (Type, Print): Janice L. Greenwood/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 129 Wye River Dr. Queenstown, MD 21658

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 9-19-97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Pulmonary Edema	1 day
Due to (or as a consequence of): b.	Congestive Heart Failure	1 year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Pneumonia	1 day
Due to (or as a consequence of): d.	Alzheimer's disease	3 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D22028

29d. Date signed (Month, Day, Year): 9 19 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul S. Rhodes, M.D. 1667 Crofton Center Crofton, Maryland 21114 (410-721-2700

State Registrar

31. Date filed (Month, Day, Year): SEP 24 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31304

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eileen Marie Gochneaur

2. Date of Death Month / Day / Year: October 1 1997

3. Time of Death: 7:33 AM

4a. Facility Name *(If not institution, give street and number)*: 37 Zion Acres Road

4b. City, Town, or Location of Death: North East

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 273-22-9669

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 15, 1927

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residance of Decedant

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 37 Zion Acres Road

10f. Zip Coda: 21901

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Homemaker

18b. Kind of Business/Industry: Her own Home

17. Fathar's Nama *(First, Middla, Last)*: George Ensman

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Ella Hertz

19a. Informant's Name/Ralationship *(Type, Print)*: Robert M. Gochneaur, Sr./Spouse

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 37 Zion Acres Road, North East, MD 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: North East Methodist Cem.

Data: Oct. 4 1997

20c. Location - City or Town, Stata: North East, Maryland

21. Signatura of Funaral Sarvica Licansaa: Robert M. Gochneaur

22. Nama and Addrass of Facility: Crouch Funeral Home, 127 South Main Street, North East, MD 21901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

PH

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Ceuse (Final disaasa or condition resulting in death)

a. congestive cardiomyopathy — 1 year

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaese or injury that initiated evants resulting in daath) Last

b. emphysema

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and due to tha ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, date and placa, and due to tha causa(s) and mannar stated.

29b. Signature and title of cartifiar: C Feuc MD

29c. Licansa number: D31712

29d. Data signad *(Month, Day, Year)*: 10/2/97

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): CHARLES ECK JR 219 W. BELAIR AVE. ABERDEEN MD 21001

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31305

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Claude Glen Grace

2. Date of Death Month Day Year: September 29, 1997

3. Time of Death: 7:36 pm

4a. Facility Name *(If not institution, give street and number)*: Residence: 134 Louisa Lane

4b. City, Town, or Location of Death: Charlestown

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 219-18-6195

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 19, 1924

9. Birthplace *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Charlestown

10d. Inside City Limits: XX Yes 2☐ No

10e. Street and Number: 134 Louisa Lane

10f. Zip Code: 21914

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Twelve Years; College (1-4or 5+): ------

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Labor Relations Representative

16b. Kind of Business/Industry: Chrysler Corporation Newark, Delaware

17. Father's Name *(First, Middle, Last)*: Charles B. Grace

18. Mother's Name *(First, Middle, Maiden Surname)*: Cora Sorlie

19a. Informant's Name/Relationship *(Type, Print)*: Cecilia Cooper Grace (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 134 Louisa Lane, P.O. Box 94, Charlestown, MD 21914

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charlestown Cemetery

Date: 10/3/97

20c. Location - City or Town, State: Charlestown, Maryland

21. Signature of Funeral Service Licensee: Lee A. Patterson Jr.

22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-0188

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 5 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ASCVD

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2XX No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H Farkas, MD

29c. License number: D15314

29d. Date signed *(Month, Day, Year)*: Sept. 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): H Farkas, MD VNA/Northern Chesapeake Hospice, Elkton, MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALMA FLETCHER GLADDEN

2. Date of Death: Month Sept. Day 30, Year 1997

3. Time of Death: 10:00PM

4a. Facility Name (If not institution, give street and number): Salisbury Center, Genesis ElderCare

4b. City, Town, or Location of Death: Salisbury, Md.

4c. County of Death: Wicomic o

Funeral Director

5. Social Security Number: 230-42-6282

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-27-05

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Virginia

10b. County: Accomack

10c. City, Town or Location: Assawoman

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 31158 Maple Drive

10f. Zip Code: 23302

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Alonza Fletcher

18. Mother's Name (First, Middle, Maiden Surname): Manie Stant

19a. Informant's Name/Relationship (Type, Print): Mary Lou Core/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Charlotte, NC

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Downings Cemetery

Date: 10-4-97

20c. Location - City or Town, State: Oak Hall, VA

21. Signature of Funeral Service Licensee: James N Fox

22. Name and Address of Facility: Fox Funeral Home, P O Box 278-Temperanceville VA 23442

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Sudden Death, Suspect Arrhythmia — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. Congestive Heart Failure — years

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Diabetes, AFIB, HTN

Hx GI Bleed

23b. **Did tobacco uae contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: M Co

29c. License number: D-39813

29d. Date signed (Month, Day, Year): 10/1/97

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804

State Registrar

31. Dete filed (Month, Day, Year): OCT 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31307

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): DR. ROBERT R. GROOMS
2. Date of Death Month Dey Yeer: September 29,1997
3. Time of Death: 11:45 pm
4e. Facility Neme (If not institution, give street end number): Memorial Hospital
4b. City, Town, or Location of Deeth: Cumberland
4c. County of Deeth: Allegany

Funeral Director

5. Socisl Security Number: 201-14-0652
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): June 17,1924
9. Birthplece (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Allegany
10c. City, Town or Location: La Vale
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 3 Linda Way
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 5+
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Psychology Professor
16b. Kind of Business/Industry: Education

17. Fether's Neme (First, Middle, Last): Robert Grooms
18. Mother's Neme (First, Middle, Maiden Surneme): Margaret Booze

19a. Informent's Name/Reletionship (Type, Print): Norma Grooms Wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3 Linda Way, La Vale, MD 21502

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): St. Ambrose Catholic Cemetery
Dete: Oct 2,1997
20c. Locetion - City or Town, Stete: Cresaptown,MD

21. Signature of Funeral Service Licensee: Douglas D Hafer
22. Neme end Address of Facility: Hafer Chapel of the Hills Mortuary 1302 National Hwy, La Vale,MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	Severe LV dysfunction	6 years
Due to (or es e consequence of):		
Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest b.	Cardiomyopathy	6 years
Due to (or es e consequence of):		
c.	Coronary artery disease	15 years
Due to (or es e consequence of):		
d.	Insulin dependent diabetes mellitus	35 years

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Chronic renal failure, depression, cachexia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Death (Check only one): Hospitel: 1☒Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: N.A. Ranjithan
29c. License number: D 19318
29d. Dete signed (Month, Dey, Yeer): Sept. 30th 97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr.N. Ranjithan-517 Oldtown Road-Cumberland, MD 21502

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 01 1997
32. Registrer's Signeture: John Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

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MS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31308

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carl Griffith

2. Data of Death Month Day Year: Sept 26 1997

3. Time of Death: 5:38PM

4a. Facility Name *(If not institution, give street and number)*: 30 Potomac Street Rear

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-14-4632

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Oct. 9, 1909

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 808 Louisiana Avenue

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Custodian

16b. Kind of Business/Industry: Timken Roller Bearing

17. Father's Name *(First, Middle, Last)*: Jackson Griffith

18. Mother's Name *(First, Middle, Maiden Surname)*: Savilla Leighty

19a. Informant's Name/Relationship *(Type, Print)*: James R. Friend/Son-in-Law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 808 Louisiana Ave., Cumberland, MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hetz Cemetery, Sept. 30, Date: 1997

20c. Location - City or Town, State: Accident, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Newman Funeral Homes, P.A., 179 Miller Street P. O. Box 275, Grantsville, MD 21536

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic heart disease — Uk yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Dpty Med Ex

29c. License number: D 09157

29d. Date signed *(Month, Day, Year)*: Sept 26 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow,M.D. 124 w 3rd st Cum Md 21502

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31309

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: FRANCES GROVER
2. Deta of Death Month Dey Year: OCTOBER 5,1997
3. Time of Death: 1150
4a. Facility Neme *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Deeth: Calvert

Funeral Director

5. Social Security Number: 220 16 8337
6. Sex: 1☐M 2☒F
7. Age *(In yrs. lest birthday)*: 87 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: August 16, 1910
9. Birthpleca *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Calvert
10c. City, Town or Location: Lusby
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 10045 H. G. Trueman Road
10f. Zip Code: 20657
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Merried 2☐Married 3☐Widowed 4☒Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yes, Give Yaar or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - Amarican Indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elamantery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Bookkeeping
16b. Kind of Business/Industry: Civil Service

17. Fether's Nema *(First, Middle, Last)*: Walter Gray
18. Mother's Name *(First, Middle, Meiden Surneme)*: Rosa Elizabeth Long

19a. Informent's Neme/Reletionship *(Type, Print)*: Gerald Grover - son
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 12932 Huron Dr. Lusby, Md. 20657

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Steta 4☐Donetion 5☐Othar *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other place)*: Middleham Chapel
Date: Oct. 9, 1997
20c. Location - City or Town, Stete: Lusby Maryland

21. Signeture of Funerel Service Licensee: BRausch
22. Neme and Address of Facility: Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic Maryland 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Cardiac arrest — Few minutes
Due to (or es a consequence of):
b. Acute Myocardial Infarction
Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es a consequence of):
c. Coronary arley Diseare. — several years.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

(1) Hypoxemic Encephalopathy
(2) Coronary arley Disease c S/P Coronary arley Bypass surg.
(3) Chronic Obstructive Pulm Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes cesa referred to medical exeminer? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☒Inpatient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐**Certifying Phyeician**: To the best of my knowledge, death occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner**: On the basis of exeminetion end/or Investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signetura and title of certifier: ATMunshi M.D. Attending Physician
29c. License number: D 19427
29d. Date signed *(Month, Day, Year)*: 10/6/97

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Dr. Anwar T. Munshi, M.D., Prince Frederick, Maryland 20678

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 06 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31310

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Geraldine Hoy
2. Date of Death (Month, Day, Year): September 26 1997
3. Time of Death: 1800
4a. Facility Name (If not institution, give street and number): Union Hospital of Cecil County
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 232-50-3660
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): May 22, 1934
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3 Kent Road
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): John Dewey Moore
18. Mother's Name (First, Middle, Maiden Surname): Rebecca Alley Mullins

19a. Informant's Name/Relationship (Type, Print): John A. Hoy
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Kent Road - Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): North East Methodist Cem. | Date: 9-30 1997
20c. Location - City or Town, State: North East, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 West Stockton Street - Elkton, MD 21921-5521

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Renal failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b. respiratory failure
Due to (or as a consequence of):
c. Obstructive sleep Apnea
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John J. Goodill M.D.
29c. License number: ~~F100~~ D37821
29d. Date signed (Month, Day, Year): 9/27/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Goodill, M.D. - Union Hospital of Cecil County - Bow Street - Elkton, MD 21921

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:5 per FH G-753 11/4/97 dh

Certificate of Death

Reg. No. 97 31311

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): THOMAS HARDY

2. Dete of Deeth — Month: SEPT. Dey: 30 Yeer: 1997

3. Time of Death: 9:11 AM

4e. Feciility Neme (If not institution, give street end number): MGH ED

4b. City, Town, or Location of Deeth: OLNEY

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Sociel Security Number: 215-48-6482 ~~215-54-6482~~

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthdey): 50 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): APRIL 1,1947

9. Birthplace (Stete or Foreign Country): WASHINGTON,D.C.

Usuel Residence of Decedent

10e. Stete: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: OLNEY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 16812 BATCHELLORS FOREST ROAD

10f. Zip Code: 20832

10g. Citizen of Whet Country?: UNITED STATES

11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yeer or Detes: 1970-1973

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Reca - Americen Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 — College (1-4or 5+): 3

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): SALESPERSON

16b. Kind of Business/Industry: CARPETS

17. Fether's Neme (First, Middle, Last): JOHN WILLIAM HARDY

18. Mother's Neme (First, Middle, Maiden Surneme): DORIS DeMERITT

19a. Informent's Neme/Relationship (Type, Print): DORIS D. HARDY, MOTHER

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 17210 FRIENDS HOUSE ROAD,SANDY SPRING,MD. 20860

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, crematory or other piece): METROPOLITAN CREMATORY

Dete: 10/2/97

20c. Locetion - City or Town, Stete: ALEXANDRIA, VA.

21. Signeture of Funerel Service Licensee: Muriel H. Barber

22. Neme and Address of Facility: MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death): e. MYOCARDIAL INFARCTION — MINUTES

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: LUNG CA

23b. Did tobacco use contributa to the cauee of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior fo completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Deeth (Check only one): Hospitel: 1☐ Inpetienf 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, streef, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner es steted. 2☒ **Medical Examiner:** On the basis of exemineiion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: MD

29c. License number: 023540

29d. Dete signed (Month, Dey, Yeer): 10/1/97

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): HUGH HILL MD 6915 RADNOR RD BETHESDA MD 20817

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 16 1997

32. Registrar's Signeture: Judy Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31312

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MITCHELL MORGAN HAMILTON
2. Date of Death (Month, Day, Year): Oct. 2, 1997
3. Time of Death: 8:15 AM
4a. Facility Name *(If not Institution, give street and number)*: 2760 Moran Drive
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 218-16-3053
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 29, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2760 Moran Drive
10f. Zip Code: 20601
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Meat Cutter
16b. Kind of Business/Industry: Grocery

17. Father's Name *(First, Middle, Last)*: Delbert Morgan Hamilton
18. Mother's Name *(First, Middle, Maiden Surname)*: Lydia C. Gates

19a. Informant's Name/Relationship *(Type, Print)*: Alice C. Hamilton-Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2760 Moran Drive., Waldorf, MD 20601

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Paul's Cemetery
Date: 10-4-97
20c. Location - City or Town, State: Waldof, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053
22. Name and Address of Facility: Huntt Funeral Home, Inc., P. O. Box 156 Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cancer Prostate	5 yr
Due to (or as a consequence of): b.	Metastatic Cancer	1 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas L Fieldson DDS
29c. License number: D01923
29d. Date signed *(Month, Day, Year)*: Oct 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Thomas L. Fieldson, 2068 Crain Highway, Waldorf, MD 20601

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 06 1997
32. Registrar's Signature: Julia Strickler-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31313

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Virginia Head

2. Date of Death Month Day Year: October 1, 1997

3. Time of Death: 9:30PM

4e. Facility Name *(If not institution, give street and number)*: 9508 Victoria Drive

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-03-0515

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 4, 1905

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 9508 Victoria Drive

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed

16b. Kind of Business/Industry: Beauty Shop

17. Father's Name *(First, Middle, Lest)*: Harry Williams

18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Chisholm

19a. Informant's Name/Relationship *(Type, Print)*: Ada E. Talbert

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9508 Victoria Drive, Upper Marlboro, Md 20772

20e. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Wood Cemetery

Date: Oct 4, 1997

20c. Location - City or Town, State: Washington,DC

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer colon

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: alzheimer symptom

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D02259

29d. Date signed *(Month, Day, Year)*: Oct 2 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Renee Grace, MD 9131 Piscataway Road Suite 260 Clinton, Maryland 20735

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 07 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joyce Anne Hubbell

2. Date of Death Month Day Year: September 14, 1997

3. Time of Death: 6:32 AM

4a. Facility Name (If not institution, give street and number): Solomon Nursing Center

4b. City, Town, or Location of Death: Solomons Landing

4c. County of Death: Calvert County

Funeral Director

5. Social Security Number: 233-48-9518

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 28, 1931

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert County

10c. City, Town or Location: Dunkirk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2604 Winesap Court

10f. Zip Code: 20754

10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Receptionist

16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Alonzo Morris

18. Mother's Name (First, Middle, Maiden Surname): Maude Evans

19a. Informant's Name/Relationship (Type, Print): Rebecca Skillin /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2604 Winesap Court, Dunkirk, Maryland 20754

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: September 16, 1997

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee #M00690: Howard A Carson

22. Name and Address of Facility: American Funeral Service, 342 Washington Street, Haverhill, MA 01832

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER — 16 mths.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. Other efgnifficant conditfons contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and placa, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-025519

29d. Date signed (Month, Day, Year): 09-14-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Atul Shah, M.D. Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Yeer): SEP 22 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 19b 10/2/97 cms AACO Health

Certificate of Death

Reg. No. 97 31315

NAME: JOHN HAPPEL
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN HENRY HAPPEL, SR.
2. Date of Death (Month, Day, Year): September 22 1997
3. Time of Death: 6:45 AM
4a. Facility Name (If not institution, give street and number): VA MHCS FORT HOWARD DIVISION
4b. City, Town, or Location of Death: FORT HOWARD
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-16-8938
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-02-1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Dacedant

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street and Number: 8025 QUARTERFIELD ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: U.S.A.

11. Maritel Statua: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Yaar or Datas: WW II
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedant's Education (Spacify only highest grada compiatad): Elamantary/Secondary (0-12): 12 | College (1-4or 5+): N/A
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): ELECTRONIC TECHNICIAN
16b. Kind of Buainasa/Industry: ELECTRONICS

17. Fathar's Nama (First, Middla, Last): HENRY HAPPEL
18. Mothar's Nama (First, Middla, Maidan Surnama): EDNA MAIER

19a. Informant's Name/Ralationship (Type, Print): BETTY L. HAPPEL (WIFE)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): ~~1025~~ 8025 QUARTERFIELD ROAD, SEVERN, MARYLAND 21144

20a. Method of Dispoaition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piaca of Disposition (Nama of cematary, crematory or othar placa): CHESAPEAKE CREMATORY, INC. Data: 9/25/97
20c. Location - City or Town, Stata: BELTSVILLE, MD.

21. Signature of Funaral Service Licansee ▶
22. Nama and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach line.

Approximata Intarval Between Onset and Death

Immediata Cause (Final disaasa or conditlon resulting in daath): a. COLON CANCER WITH METASTASIS — 5 YEARS
Dua to (or as a consequance of):
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or injury that initiated events rasulting in daath) Last:
b. Dua to (or as a consequance of):
c. Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

STATUS POST URETHRAL STENT FOR BILATERAL HYDRONEPHROSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was cese rafarred to medical examinar? 1 [ ] Yes 2 [X] No

28. Placa of Daath (Check only ona): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Othar: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Othar (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 8 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, atraat, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signatura and title of cartifiar ▶
29c. Licansa number: D30528
29d. Data signed (Month, Day, Year): Sept 22nd, 1997

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Bala Duggirala, MD 9600 North Point Road Fort Howard, MD 21052

State Registrar

31. Data filed (Month, Day, Year): SEP 23 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31316

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH F. HALEY
2. Date of Death Month Day Year: SEPT 21 97
3. Time of Death: 10:40A
4a. Facility Name (If not institution, give street and number): Wilson Health Care Center
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 230-14-4275
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 19, 1919
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 301 Russell Avenue
10f. Zip Code: 20877
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Editor
16b. Kind of Business/Industry: (Unavailable)

17. Father's Name (First, Middle, Last): Boyd Franklin
18. Mother's Name (First, Middle, Maiden Surname): Mary Eva Sutphin

19a. Informant's Name/Relationship (Type, Print): Robert L. Haley - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 273 Monterey, Virginia 24465

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Prospect Hill Cemetery
Date: 9/26/97
20c. Location - City or Town, State: Front Royal, Virginia

21. Signature of Funeral Service Licensee: Helen W. Dove
22. Name and Address of Facility: Maddox Funeral Home 105 W. Main Street Front Royal, Virginia

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASPHYXIA — ACUTE
Due to (or as a consequence of):
b. DEMENTIA — YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D07099
29d. Date signed (Month, Day, Year): SEPT. 21 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS C. MAGHE 10215 FERNWOOD RD BETHESDA MD 20817

State Registrar

31. Date filed (Month, Day, Year): SEP 26 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31317

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Loretta Holmes

2. Date of Death Month Day Year: September 22, 1997

3. Time of Death: 13:40

4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical System

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 254-48-9679

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 11 1934

9. Birthplace *(State or Foreign Country)*: GEORGIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ODENTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1225 QUEEN ANN AVENUE

10f. Zip Code: 21113

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 8th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CUSTODIAN

16b. Kind of Business/Industry: DEPARTMENT OF DEFENSE

17. Father's Name *(First, Middle, Last)*: ROSCOE WALTON

18. Mother's Name *(First, Middle, Maiden Surname)*: LAURA PATE

19a. Informant's Name/Relationship *(Type, Print)*: LOVETT HOLMES (HUSBAND)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1225 QUEEN ANN AVENUE ODENTON, MD. 21113

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETERAN CEMETERY

Date: 9/26/97

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Harry D. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death): e. Respiratory Failure

Due to (or es e consequence of): COPD

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted.

29b. Signature end title of certifier: ▶ Michael G. Rolnick M.D

29c. License number: D41396

29d. Date signed *(Month, Day, Yeer)*: September 22, 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Michael Rolnick 22 South Greene Street Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31318

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE ROMAIN HOLLOWAY

2. Date of Death (Month, Day, Year): September 27, 1997

3. Time of Death: 7:10 Am

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-01-1507

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 19, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 416 Giles St.

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Howard Michael Heck

18. Mother's Name (First, Middle, Maiden Surname): Margaret Alice Fleming

19a. Informant's Name/Relationship (Type, Print): Patricia N. Trout - daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 W. Heather Rd., Bel Air, Md. 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rock Run Cemetery

Date: 9-29-97

20c. Location - City or Town, State: Havre de Grace, Md.

21. Signature of Funeral Service Licensee: Stephen A Douglas

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

-DM -CHOLELITHIASIS -OA -OSTEOPOROSIS

-POLYNEUROPATHY -PUD -CA CERVIX

-ASCVD -SENILITY -DIVERTICULITIS

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Bandla MD

29c. License number: D42800

29d. Date signed (Month, Day, Year): 9/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. Bandla, 3195 Union Blvd., Apt 6, Mod, 21078

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997

32. Registrar's Signature: Barbara Bartell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Holloway, Catherine R.
Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31319

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Dale HANSELL
2. Date of Death Month Dey Yaer: SEPTEMBER 26, 1997
3. Time of Death: 5:25 PM
4a. Facility Name (If not institution, give street and number): Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-18-5239
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 75 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 01-05-1922
9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. Stete: MD
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1 [X] Yas 2 [ ] No
10e. Street end Number: 75 Starboard Court
10f. Zip Coda: 21903
10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Detes: ?
13. Was Decadant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decadent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Guard
16b. Kind of Business/Industry: Federal Reserve

17. Fether's Neme (First, Middle, Last): Edward Frank Hansell
18. Mothar's Nema (First, Middle, Maiden Surneme): Virginia Alamong

19a. Informent's Name/Relationship (Type, Print): Mrs. Theresa L. Hansell - Wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 75 Starboard Court, Perryville, MD 21903

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Remaval from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Nema of cemetery, crematory or other place): Angel Hill Cemetery
Date: 9/29/97
20c. Location - City or Town, State: Havre de Grace, MD

21. Signeture of Funaral Sarvice Licensee: William L. Smith II
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Finel diseese or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: ACUTE RENAL FAILURE

23b. **Did tobacco uee contribute to the cause of deeth?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings eveileble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Cartifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D30263
29d. Date signed (Month, Day, Yaer): 9-26-97

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KHOO, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Dete filed (Month, Day, Year): SEP 29 1997
32. Registar's Signeture: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Hansell Joseph Dale

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31320

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ESTHER HARRIS

2. Date of Death Month OCT Day 2 Year 1997

3. Time of Death: 11:20 AM

4a. Facility Name (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 213-01-5685

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 25, 1918

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: CAROLINE

10c. City, Town or Location: GREENSBORO

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12716 RIDGELY ROAD

10f. Zip Code: 21639

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BOOKKEEPER/SECRETARY

16b. Kind of Business/Industry: FISHERMAN'S SEAFOOD MARKET

17. Father's Name (First, Middle, Last): GEORGE JEWELL

18. Mother's Name (First, Middle, Maiden Surname): RUBY EATON

19a. Informant's Name/Relationship (Type, Print): ANN HARRIS / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12716 RIDGELY ROAD, GREENSBORO, MD 21639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK

Date: 10-6-97

20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: John R. Mercer for CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
- e. Congestive heart failure — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
- b. acute renal failure — days

Due to (or as a consequence of):
- c. uro sepsis — days

Due to (or as a consequence of):
- d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zaki M.D.

29c. License number: D47534

29d. Date signed (Month, Day, Year): 10/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WAFIK ZAKI, M.D., 920 MARKET ST., DENTON, MD 21629

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

HARRIS, MARY

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31321

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Howard Gibson Henry, Sr.

2. Dete of Death (Month, Dey, Year): September 29, 1997

3. Time of Death: 10:40 am

4a. Feclity Name (If not institution, give street end number): Union Hospital of Cecil County

4b. City, Town, or Location of Deeth: Elkton

4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 212-30-4752

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthday): 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): November 29 1916

9. Birthplece (Stete or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 500 Piney Creek Lane

10f. Zip Code: 21901

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: US Navy WWII

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Owner / Operator

16b. Kind of Business/Industry: Retail Hardware/Supply Store

17. Fether's Neme (First, Middle, Last): John Norman Henry

18. Mother's Neme (First, Middle, Meiden Surneme): Mary Gibson

19e. Informent's Neme/Reletionship (Type, Print): Judith O. Henry / Spouse

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 500 Piney Creek Lane, North East, MD 21901

20e. Method of Disposition: 1☐ Burie! 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): R.A. Ferris Crematory

Dete: Oct. 2 1997

20c. Locetion - City or Town, Stete: West Chester, Penna.

21. Signeture of Funerel Service Licensee: Robert J. Crouch

22. Neme end Address of Feclity: Crouch Funeral Home 127 South Main Street, North East, MD 21901

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arreet, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth)

a. Aspiration Pneumonia — < 2 week

Due to (or es e consequence of):

b. Parkinson's Dementia + Disease — 3-6 years

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? Brain Biopsy at Jeff. 1☑ Yes 2☐ No

24b. Were autopsy findings evailable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one): Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Joseph K. Weidner Jr., MD

29c. License number: D44373

29d. Dete signed (Month, Day, Yeer): 9/29/97

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 101 Colonial Way Fishing Creek MD 21911

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 02 1997

32. Registrar's Signature:

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31322

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernard Graham Howell
2. Date of Death Month / Day / Year: October 2 1997
3. Time of Death: 8:39 AM
4a. Facility Name *(If not institution, give street and number)*: 6 East Parkway
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 235-46-2115
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 10, 1931
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: CECIL
10c. City, Town or Location: ELKTON
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6 East Parkway
10f. Zip Code: 21921
10g. Citizen of What Country?: US

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Auto Worker
16b. Kind of Business/Industry: Automotive/Crysler

17. Father's Name *(First, Middle, Last)*: Roger William Howell
18. Mother's Name *(First, Middle, Maiden Surname)*: Allie Graham

19a. Informant's Name/Relationship *(Type, Print)*: Shirley Howell/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6 East Parkway Elkton, Maryland 21921

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Nottingham Babtist Cemetery
Date: 10-5-1997
20c. Location - City or Town, State: Nottingham, PA

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Robert T. Jones/Foard, Inc. 122W. Main St. Newark

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: DE

Immediate Cause (Final disease or condition resulting in death):
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Cardiomyopathy
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Tobacco Abuse

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D 33570
29d. Date signed *(Month, Day, Year)*: 10/3/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suite 52 People Plaza Glasgow De 19702

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 03 1997
32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katharine nmi Jordan

2. Date of Death (Month, Dey, Yeer): September 21, 1997

3. Time of Death: 9:40 am

4a. Facility Neme (If not Institution, give street end number): Chesapeake Healthcare

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 058-30-9659

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): May 21, 1909

9. Birthplece (State or Foreign Country): Kansas

Usuel Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 305 College Parkway

10f. Zip Code: 21012

10g. Citizen of Whet Country?: USA

11. Mertel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12+ | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Fether's Neme (First, Middle, Last): Albert Elwin King

18. Mother's Name (First, Middle, Maiden Surneme): Frances Amanda Clouston

19a. Informent's Neme/Relationship (Type, Print): Frances Lewis/daughter

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 266 Oak Court, Severna Park, MD 21146

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Metro Crematory | Dete: Sept 22 1997

20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funeral Service Licensee: James E. Barranco

22. Neme end Address of Feciliity: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy., Severna Park, MD 21146

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Congestive Heart Failure — 1 week

Due to (or es e consequence of): b. Coronary Artery Disease — 5 Years

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last

Due to (or es e consequence of): c.

Due to (or es e consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Previous Myocardial Infarction

Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner stated.

29b. Signeture end titie of certifier: Attending Doctor

29c. License number: D21684

29d. Dete signed (Month, Dey, Yeer): 9-22-97

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): C.V. CYRIAC. M.D 8109 RITCHIE HWY, PASADENA, MD 21122

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): SEP 25 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31324

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET LENA JONES

2. Date of Death Month Day Year: SEPT. 21 1997

3. Time of Death: 15:25 pm

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-05-4970

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MARCH 7 1912

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10e. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: EDGEWATER

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1213 SHESLEY ROAD

10f. Zip Code: 21037

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 6th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC

16b. Kind of Business/Industry: OUT SIDE THE HOME

17. Father's Name *(First, Middle, Last)*: SAMUEL JONES

18. Mother's Name *(First, Middle, Maiden Surname)*: QUEENIE BROWN

19a. Informant's Name/Relationship *(Type, Print)*: CHARLENE C. ADAMS (GRANDAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7809 CITADEL DRIVE SEVERN, MD. 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND NATIONAL MEM. PARK

Date: 9/25/97

20c. Location - City or Town, State: LAUREL, MD.

21. Signature of Funeral Service Licensee: ▶ Larry G. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	CONGESTIVE HEART FAILURE	1995
Due to (or as a consequence of): b.	CORONARY ARTERY DISEASE	1984
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	TYPE I DIABETES MELLITUS	1987
Due to (or as a consequence of): d.	HYPERTENSION	1984

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Donald C. Rowe, M.D.

29c. License number: D 10658

29d. Date signed *(Month, Day, Year)*: 9/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Donald C. Rowe, M.D. 1616 FOREST DRIVE ANNAPOLIS 21403

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31325

Certificate of Death

Reg. No.

CALVIN JONES SR.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Calvin W. Jones, Sr.

2. Date of Death Month: 9 Day: 28 Year: 97

3. Time of Death: 18:16

4a. Facility Name *(If not institution, give street and number)*: Dorchester General Hospital 300 Byrn St.

4b. City, Town, or Location of Death: Cambridge, MD

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 218-30-2211

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 07/10/32

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Dorchester | 10c. City, Town or Location: Hurlock | 10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: P.O. Box 1120 | 10f. Zip Code: 21643 | 10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3rd | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: Edward Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Della Stanley

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Jones (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1120, Hurlock, Maryland 21643

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: East New Market Cemetery | Date: 10/4/97 | 20c. Location - City or Town, State: East New Market, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Bennie Smith Funeral Home, P.O.Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardiac arrhythmia — Approximate Interval: 3 minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease; Sarcoidosis; Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Mark Malkus, MD

29c. License number: D50804

29d. Date signed *(Month, Day, Year)*: 9/28/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mark Malkus, MD 408 Byrn Street Cambridge, MD 21613

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: [signature] Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31326

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCIS ALLEN JONES
2. Date of Death Month / Day / Year: SEPT 30, 1997
3. Time of Death: 11:20 A.M.
4a. Facility Name *(If not institution, give street and number)*: 87 WEST MAIN STREET
4b. City, Town, or Location of Death: FROSTBURG
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217 38 4248
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: OCT 12, 1943
9. Birthplace *(State or Foreign Country)*: NEW YORK

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 87 WEST MAIN STREET
10f. Zip Code: 21532
10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MECHANIC
16b. Kind of Business/Industry: GARAGE

17. Father's Name *(First, Middle, Last)*: GERALD T. JONES
18. Mother's Name *(First, Middle, Maiden Surname)*: ALICE CAVANAUGH

19a. Informant's Name/Relationship *(Type, Print)*: GERALDINE SCHURG / SISTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10103 COTTAGE LANE, FROSTBURG, MD 21532

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: THE CUMBERLAND CREMATORY — Date: 10/1/97
20c. Location - City or Town, State: CUMBERLAND, MD 21502

21. Signature of Funeral Service Licensee: Marilou M. Sowers
22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA ESOPHAGUS — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALCOHOL & NICOTINE ABUSE

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D09157
29d. Date signed *(Month, Day, Year)*: SEPT. 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL SNOW, M.D., DPTY MED EX 124 W. 3RD ST., CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 03 1997
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31327

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Evans Kumbar
2. Date of Death: Month 09 Day 16 Year 1997
3. Time of Death: 1230
4a. Facility Name (If not institution, give street and number): 1050 Lord Cecil Drive
4b. City, Town, or Location of Death: Owings
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 232 66 2100
6. Sex: 1☐ M 2☒ F
7. Age (in yrs. last birthday): 57 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/13/1939
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Owings
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1050 Lord Cecil Drive
10f. Zip Code: 20736
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): H. Quay Evans
18. Mother's Name (First, Middle, Maiden Surname): Opal Fearer

19a. Informant's Name/Relationship (Type, Print): Joseph Kumbar (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1050 Lord Cecil Drive/Owings MD 20736

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft Lincoln Cemetery
Date: 9/19
20c. Location - City or Town, State: Brentwood MD

21. Signature of Funeral Service Licensee: ▶ M. D. Wilhelm Nagorne
22. Name and Address of Facility: Advent Funeral & Cremation Services Annapolis MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Cancer
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ JT
29c. License number: MD 018320
29d. Date signed (Month, Day, Year): 9/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John TEMING MD Johns Hopkins Oncology Ctr Balto MD 21287

State Registrar

31. Date filed (Month, Day, Year): SEP 22 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31328

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen KAZARES

2. Date of Death Month: 9 Day: 19 Year: 97

3. Time of Death: 8:30 AM

4a. Facility Name (If not institution, give street and number): Mariner Health Care

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 164-10-0607

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 12, 1912

9. Birthplace (State or Foreign Country): Russia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Montgomery | 10c. City, Town or Location: Germantown | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11218 Winding Brook Lane | 10f. Zip Code: 20876 | 10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Rubin Kutler

18. Mother's Name (First, Middle, Maiden Surname): Leah Chevafsky

19a. Informant's Name/Relationship (Type, Print): Richard Kazares Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11218 Winding Brook Lane, Germantown, MD 20876

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Star of David Mem. Gardens | Date: Sept 22, 1997

20c. Location - City or Town, State: North Lauderdale, FL

21. Signature of Funeral Service Licensee: Helen W. Rose

22. Name and Address of Facility: Star of David Memorial Chapel, 7701 Bailey Road, North Lauderdale, FL 33068

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC ADENOCARCINOMA OF LUNG — YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Martin C. Sharget M.D.

29c. License number: D08944

29d. Date signed (Month, Day, Year): 9/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARTIN C. SHARGEL M.D. 3720 FARRAGUT AVE KENSINGTON - MD 20895

State Registrar

31. Date filed (Month, Day, Year): SEP 26 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31329

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH MAY KUHL

2. Date of Death (Month, Day, Year): September 28 1997

3. Time of Death: 3:15 pm

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne ARUNDEL

Funeral Director

5. Social Security Number: 218-01-0288

6. Sex: 1☐ M XX F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/21/1920

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1011 UPTON ROAD

10f. Zip Code: 21060

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4 or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): GEORGE OLIVER McMECHAN

18. Mother's Name (First, Middle, Maiden Surname): MARY (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): JOHN WAYNE KUHL (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8210 ELVATON DRIVE, PASADENA, MD. 21122

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK

Date: 10/2/97

20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: Michael C. Taffion

22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cerebravascular Accident — 1½ months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Aspiration Pneumonia

Due to (or as a consequence of):

c. Chronic OBstructive lung Disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joyce M. Ramirez MD

29c. License number: D36256

29d. Date signed (Month, Day, Year): September 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOYCE M. RAMIREZ MD 7845 Oakwood Rd Suite 106 Glen Burnie

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997

32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Elizabeth M. Kuhl

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

97 31330

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harold Arthur Klempke			2. DATE OF DEATH (Month, Day, Year): Oct. 01, 1997	3. TIME OF DEATH: 9:04 A M
4. SOCIAL SECURITY NUMBER: 394-18-0567	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-06-23	8. BIRTHPLACE (State or Foreign Country): Wisconsin
9a. FACILITY NAME (If not institution, give street and number): 6644 Lukes Lane		9b. CITY, TOWN OR LOCATION OF DEATH: Snow Hill		9c. COUNTY OF DEATH: Worcester
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Snow Hill		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6644 Lukes Lane		10f. ZIP CODE: 21863		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W. II (Army)	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): maintenance		16b. KIND OF BUSINESS/INDUSTRY: Poultry Industry
17. FATHER'S NAME (First, Middle, Last): Arthur Klempke		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Klempke		
19a. INFORMANT'S NAME (Type/Print): Betty Klempke		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6644 Lukes Lane, Snow Hill, Md. 21863		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Crematory	DATE: 10/2	20c. LOCATION — City or Town, State: Salisbury, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patricia L. Dennis		22. NAME AND ADDRESS OF FACILITY: P.O. Box 87 Dennis Funeral Home, Snow Hill, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. lung Cancer	2 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease
Diabetes

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [X] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Patricia Mahoney MD	D46490	▶ 10-1-97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Patricia K. Mahoney, MD 428 W. Market Street Snow Hill, Md 21863

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
OCT 02 1997	Julia Davidson-Randall

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DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31331

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET ELLEN KASTNER

2. Date of Death Month Day Year: OCTOBER 5, 1997

3. Time of Death: 1520

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-38-2321

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT 5 1941

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 15710 WINSLOW STREET S.W.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 + 1 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSE KEEPER

16b. Kind of Business/Industry: HOUSE KEEPER

17. Father's Name *(First, Middle, Last)*: BERNARD F. COYLE SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: MARIE A. SHANNON

19a. Informant's Name/Relationship *(Type, Print)*: JOHN RICHARD KASTNER HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15710 WINSLOW STREET S.W. CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: CUMBERLAND CREMATORY

Date: OCTOBER 6 1997

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory failure — 5 days

Due to (or as a consequence of):

b. Bilateral pneumonia — 5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Massive stroke — 3 months

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: DO 8377

29d. Date signed *(Month, Day, Year)*: OCTOBER 5 , 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR URIEL VELANDIA 924 SETON DRIVE CUMBERLAND MARYLAND 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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MD

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 07 1997

32. Registrar's Signature: Jake Thurston-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31332

STELLA R. LECHERT

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Stella Rose Lechert
2. Date of Death Month Dey Year: September 19, 1997
3. Time of Death: 1:25 p.m.
4a. Facility Name *(If not institution, give street and number)*: Chesapeake Healthcare
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-07-7663
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Aug 20, 1913
9. Birthplece *(State or Foreign Country)*: W. Virginia

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 183 Topeg Drive
10f. Zip Code: 21146
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Psychiatric Aide
16b. Kind of Business/Industry: Shepherd Pratt Hospital

17. Fether's Neme *(First, Middle, Last)*: Alexander Kolakowski
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mary

19a. Informent's Neme/Reletionship *(Type, Print)*: Marlene Hodges/daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 183 Topeg Drive, Severna Park, MD 21146

20e. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☒ Other *(Specify)* Entombment
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Parkwood Cemetery
Dete: Sept 23 1997
20c. Location - City or Town, Stete: Baltimore, MD

21. Signeture of Funerel Service Licensee: ▶ Robert S. Barranco
22. Neme end Address of Feclility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Death
Immediete Ceuse (Finel diseese or condition resulting in death) e.	SEIZURE DISORDER	2 yrs
Due to (or as e consequence of):	DEMENTIA	2 yrs
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest — b. Due to (or es e consequence of):		
c. Due to (or es e consequence of):		
d.		

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete and placa, and due to the cause(s) end manner stated.

29b. Signeture end title of certifier: ▶ M. Nussaire
29c. License number: D 40519
29d. Dete signed *(Month, Dey, Year)*: 9.19.97.

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): M. Nussaire, M.D. 795 Aquahart Road, Glen Burnie, Md 21061

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: SEP 25 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND # 19b 9-25-97 cms AACO

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31333

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ELLSWORTH MILTON LUTZ, SR.
2. Date of Death (Month, Dey, Yeer): SEPTEMBER 24, 1997
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, giva street and number): 101 BETH ROAD
4b. City, Town, or Location of Deeth: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 212-05-4607
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Yeer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): OCT. 12, 1911
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 101 BETH ROAD
10f. Zip Code: 21060
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): FOREMAN
16b. Kind of Business/Industry: BALTIMORE GAS AND ELECTRIC COMPANY

17. Fether's Neme (First, Middle, Last): MARTIN H. LUTZ
16. Mother's Name (First, Middle, Maiden Surname): MARY BOSZ

19a. Informant's Name/Reiationship (Type, Print): HILDA LUTZ (WIFE)
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 101 BETH ROAD, GLEN BURNIE, MARYLAND ~~21061~~ 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Placa of Disposition (Nama of cemetary, cramatory or othar place): MORELAND MEMORIAL PARK
Date: 9/27/97
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: Michael C. Faffon
22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Acute renal failure — 1 day
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Neturai 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture end titie of certifier:
29c. License number: D23624
29d. Date signed (Month, Day, Year): Sept 25, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BASANT CHANDELWAL M.D 1600 S. CRAIN Highway Glen Burnie MD 21061

State Registrar

31. Date filed (Month, Day, Year): SEP 25 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31334

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emma Lavinia Little

2. Date of Death Month Day Year: September 27, 1997

3. Time of Death: 8:20a.m.

4a. Facility Name *(If not institution, give street and number)*: Med Pointe Nursing Home

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 216-12-8090

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 7, 1919

9. Birthplace *(State or Foreign Country)*: Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 151 Bay Blvd.

10f. Zip Code: 21078

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly line worker

18b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Thomas Hurst

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Shaddix

19a. Informant's Name/Relationship *(Type, Print)*: Christine M. Little(daughter-in-law)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 106 Orpah Drive, Elkton, Maryland 21921

20a. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Angel Hill Cemetery

Date: 10/1/97

20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: Kirsten Amy Unglesbee

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Ca.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CA Lung

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- A. Schizophrenia
- Hypothyroidism
- Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D42800

29d. Date signed *(Month, Day, Year)*: 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 319 S. Union Ave, Havre de Grace, MD 21078

3

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: [signature] Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31335

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY CORENA LORD

2. Date of Death (Month, Day, Year): Sept. 30, 1997

3. Time of Death: 9:40 AM

4a. Facility Name *(If not institution, give street and number)*: 5514 Maple Drive

4b. City, Town, or Location of Death: Federalsburg

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 241-44-4780

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 10, 1933

9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: Dorchester

10c. City, Town or Location: Federalsburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5514 Maple Drive

10f. Zip Code: 21632

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 2 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sewing Machine Oper.

16b. Kind of Business/Industry: Garment Worker

17. Father's Name *(First, Middle, Last)*: Floyd Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Edna Osborn

19a. Informant's Name/Relationship *(Type, Print)*: Clarence Lord/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5514 Maple Drive , Federalsburg, MD. 21632

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Capital Crematory | Date: 10/1/97

20c. Location - City or Town, State: Dover, Del.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Williamson Funeral Home Federalsburg, Maryland 21632

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Cancer unknown primary less than 1 year

Due to (or as a consequence of):
b. |

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bronchitis
CHF, Hypertension
CAD, Peptic Ulcer Disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury: ___ M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lois Lam D.O.

29c. License number: H 41615

29d. Date signed *(Month, Day, Year)*: 9/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Lois L. Lam D.O. 215 Bloomingdale Ave. Fed. MD 21632

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 02 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Travis Mullins
2. Date of Death (Month, Day, Year): September 24, 1997
3. Time of Death: 10:40 am
4a. Facility Name (If not institution, give street and number): 5713 67th Avenue
4b. City, Town, or Location of Death: Riverdale
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 414-70-3416
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 22, 1943
9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5713 67th Avenue
10f. Zip Code: 20737
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1963-1967
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Roofer/Truck Driver
16b. Kind of Business/Industry: Orndroff & Spaid Roofing

17. Father's Name (First, Middle, Last): Isaac Mullins
18. Mother's Name (First, Middle, Maiden Surname): Laura Patterson

19a. Informant's Name/Relationship (Type, Print): Dorothy Mullins - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5713 67th Avenue, Riverdale, Maryland 20737

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Goshen Valley Cemetery | Date: 9/28/97
20c. Location - City or Town, State: Church Hill, Tennessee

21. Signature of Funeral Service Licensee: ▶ Nancy J. Thompson
22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. GLIOBLASTOMA MULTIFORME — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in death) Lest
b. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEEP VENOUS THROMBOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Sajeev Anand. M.D.
29c. License number: D33482
29d. Date signed (Month, Day, Year): September 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sajeev Anand, M.D. 7343A Hanover Parkway, Greenbelt, Maryland 20770

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julia Brudon-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31337

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHY WILDUNG MILLER

2. Date of Death Month Day Year: October 02, 1997

3. Time of Death: 10:00a.m.

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 072-09-1412

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 11, 1916

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Leonartown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 21585 Peabody Street

10f. Zip Code: 20650

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: At Home

17. Father's Name *(First, Middle, Last)*: Henry George Wildung

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Gallagher

19a. Interment's Name/Raletionship *(Type, Print)*: Nancy M. Hughes ,Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9439 May Day Street , La Plata, Maryland 20646

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 10/5/97

20c. Location - City or Town, State: Alexandria,Va.

21. Signature of Funeral Service Licensee: D C Echols M-00174

22. Name and Address of Facility: AREHART-ECHOLS FUNERAL HOME,INC. P.O. BOX 567, LA PLATA, MD. 20646

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Failure — hrs

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary D. — yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: James P. Jarboe M.D

29c. License number: D 0619

29d. Date signed *(Month, Day, Year)*: 10-2-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. JAMES P. JARBOE PHILIP J. BEAN MEDICAL CENTER, HOLLYWOOD, MD 20636

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 03 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: DOROTHY MILLER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George E McGonigal
2. Date of Death: Month: Sept Day: 30 Year: 97
3. Time of Death: 5:35 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 270-09-0672
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 2, 1914
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7455 Bensville Road
10f. Zip Code: 20603
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+): N/A
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Snack Food

17. Father's Name (First, Middle, Last): Daniel McGonigal
18. Mother's Name (First, Middle, Maiden Surname): Mary Gallagher

19a. Informant's Name/Relationship (Type, Print): Gary Edward McGonigal (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24 Lord Fairfax Drive Fredericksburg, VA 22405

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery Date: Oct. 2, 1997
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: ▶ H. E. Lee
22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Bilateral Aspiration Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. MRSA - Staph aureus
Due to (or as a consequence of):
d. PEG - gastrotomy tube

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Esophageal Structures

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ G.K. Edgecombe MD
29c. License number: D23826.
29d. Date signed (Month, Day, Year): 9/30/97.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Glenn R. Edgecombe MD 7700 Old Branch Ave Clinton MD 20735

State Registrar

31. Date filed (Month, Day, Year): OCT 07 1997
32. Registrar's Signature: Julia Dawson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31339

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emily Muller

2. Date of Death Month Day Year: Oct 3, 1997

3. Time of Death: 12:40 AM

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 139 14 2151

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 97 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 21, 1900

9. Birthplace *(State or Foreign Country)*: Phoenixville, Pa

Usual Residence of Decedent

10a. Stete: MD

10b. County: PG

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3904 23rd Place

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Meritei Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bieck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ribbon Weaver

16b. Kind of Business/Industry: Mill

17. Father's Name *(First, Middle, Last)*: Jacob Saner

18. Mother's Name *(First, Middle, Maiden Surneme)*: Emily Muster

19a. Informant's Neme/Relationship *(Type, Print)*: Edmund Stecher (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 548 Marc Road, Millersville, Maryland 21108

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Cedar Lawn Cemetery — Date: Oct 7, 1997

20c. Location - City or Town, Stete: Paterson, New Jersey

21. Signature of Funeral Service Licansee: Charles L. Bélanger

22. Name end Address of Feciiity: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road Clinton, Maryland 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. arteriosclerotic cardiovascular disease — years

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

fractured hip

urinary tract infection

infected sacral decubitus ulcer

23b. Did tobacco uss contributs to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piaca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: [signature]

29c. License number: D18545

29d. Dete signed *(Month, Dey, Year)*: 10/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Wisotsky, 700 Old Line Center, Suite 207, Waldorf, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 0 7 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — 97 31340

Item:3 per Physician,item:8 per F.H. G-752 10/7/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence Wilbur Moore

2. Date of Death (Month, Day, Year): October 2,1997

3. Time of Death: 6:00 ~~AM~~ PM

4a. Facility Name (If not institution, give street and number): 6905 Dowerhouse Road

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 219-01-5693

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9/24/13 ~~Sept. 9,1913~~

9. Birthplace (State or Foreign Country): Washington DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6905 Dowerhouse Road

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retail Owner

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Clarence Oliver Moore

18. Mother's Name (First, Middle, Maiden Surname): Mary Magdeline Boswell

19a. Informant's Name/Relationship (Type, Print): Michael Oliver Moore (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50114 Manley Chapel Hill N.C. 27514

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery — Date: October 06, 1997

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Reynold [illegible]

22. Name and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarct — Hr

Due to (or as a consequence of):
b. Arteriosclerotic Cardiac Disease — Yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas L Fieldson MD

29c. License number: D01923

29d. Date signed (Month, Day, Year): Oct 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas L. Fieldson M.D. 2068 Crain Highway Pinefield Square Waldorf, MD

State Registrar

31. Date filed (Month, Day, Year): OCT 0 7 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31341

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hattie McPherson
2. Date of Death Month: 9 Day: 12 Yeer: 97
3. Time of Death: 0340 AM
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel General Medical
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-24-7589
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 5/12/11
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 115 Clay Street
10f. Zip Code: 21401
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic
16b. Kind of Business/Industry: Home maker

17. Father's Name *(First, Middle, Last)*: William McPherson
18. Mother's Name *(First, Middle, Maiden Surneme)*: Hattie McGowans

19a. Informant's Neme/Reletionship *(Type, Print)*: Joseph B. Smith Jr.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7919 Putney Terr. Glen Burnie, Md 21061

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Brewer Hill — Date: 9/17/97
20c. Location - City or Town, Stete: Annapolis, Md.

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name end Address of Feciility: House of Dicks F/H 1922 Forest Drive Annapolis, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List *only* one cause on eech line.

Approximete Interval Between Onset end Deeth

Immedlete Ceuse (Finel diseese or condition resulting in deeth):
- e. Septicemia — 2 days

Due to (or es e consequence of):
- b. Biliary Obstruction — 5 days

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest:
- Due to (or es e consequence of):
- c.
- Due to (or es e consequence of):
- d.

Part II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Dementia

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☑ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the besis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Stephen Hausman MD
29c. License number: D27388
29d. Dete signed *(Month, Dey, Yeer)*: 9/13/97

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): 200 Harry Truman Pkwy. #350, Annapolis, MD. 21401

State Registrar

31. Date filed *(Month, Day, Yeer)*: SEP 19 1997
32. Registrar's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rafael Maysonet

2. Date of Death: Month: September; Day: 14; Year: 1997

3. Time of Death: 6:49

4a. Facility Name (If not institution, give street and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 058242642

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): 04011912

9. Birthplace (State or Foreign Country): Puerto Rico

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 83-21 MindaleCircle

10f. Zip Code: 21244

10g. Citizen of What Country? United States of America

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Carton Manufacturing

17. Father's Name (First, Middle, Last): Armondo Maysonet

18. Mother's Name (First, Middle, Maiden Surname): Josefina Morales

19a. Informant's Name/Relationship (Type, Print): Eva DeLeon Maysonet/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 83-21 MindaleCircle, Baltimore, Maryland 21244

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fresh Pond Crematory

Date: September 18, 1997

20c. Location - City or Town, State: Middle Village, New York

21. Signature of Funeral Service Licensee: #M00690 Howard A Carson

22. Name and Address of Facility: Papavero Funeral Home, 72-27 Grand Avenue, Maspeth, New York

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neill King MD Resident

29c. License number: AS240232 / LK9438

29d. Date signed (Month, Day, Year): September 14 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sinai Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): SEP 22 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31343

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH THOMAS MORAN, SR.

2. Date of Death (Month, Day, Year): Sept 18 1997

3. Time of Death: 07:25AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-10-0732

6. Sex: 1☒ M 2☐ F

7. Age (In yrs last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 17, 1918

9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: LINTHICUM

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 525 FOREST VIEW ROAD

10f. Zip Code: 21090

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ENGINEER

16b. Kind of Business/Industry: ELECTRONICS

17. Father's Name (First, Middle, Last): THOMAS MORAN

18. Mother's Name (First, Middle, Maiden Surname): MARY MALLOY

19a. Informant's Name/Relationship (Type, Print): LEAH MARY MORAN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 525 FOREST VIEW ROAD, LINTHICUM, MD. 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK

Date: 9/22/97

20c. Location - City or Town, State: ELKRIDGE, MARYLAND

21. Signature of Funeral Service Licensee: Michael C. Gaffian

22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATHEROSCLEROSIS

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: 025782

29d. Date signed (Month, Day, Year): 9-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN [illegible] 7575 ARUNDEL MNR GLEN BURNIE, MD

State Registrar

31. Date filed (Month, Day, Year): SEP 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Moran, Sr Joseph T

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31344

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month / Day / Year	3. Time of Death
JAMES P. MASSENBURG	SEPT 23 1997	0801

4a. Facility Name (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
1800 Meade Court	Millersville	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Aga (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Day, Year)	9. Birthplaca (State or Foreign Country)
248 60 0180	1☒M 2☐F	59 Yrs.			02/19/1938	Ravenel, SC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	Anne Arundel	Millersville	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
1800 Meade Court	21108	USA

11. Meritel Status	12. Was Decedent Evar in U.S. Armed Forces? If Yas, Giva Yaar or Datas:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No 1956 - 1959	1☐Yas 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	Collega (1-4or 5+)		
	1	Federal Government Employee	National Security Admin

17. Father's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Ringold Massenburg	Agnes Godfrey

19a. Informent's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Joy Massenburg (wife)	1800 Meade Court/Millersville MD 21108

20a. Mathod of Disposition	20b. Place of Disposition (Nama of cemetary, cramatory or othar place)	Date	20c. Location - City or Town, Stata
1☐Burial 2☒Cremation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)	Metropolitan Crematory	9/24	Alexandria VA

21. Signature of Funaral Sarvica Licansee	22. Name and Addrass of Facility
▶ Melanie Wilhelm Hagner	Advent Funeral & Cremation Services Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complications thet caused the death. Do not anter the moda of dying, such as cardiac or respiratory errest, shock, or haart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immedieta Causa (Final diseasa or condition resulting in death) a.	METASTATIC COLON CANCER	14 months
Dua to (or as a consequance of):		
Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaase or injury that initiated evants resulting in death) Last b.		
Dua to (or as a consequence of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No 3☐Probably 4☐Unknown	1☐Yes 2☒No	1☐Yas 2☐No

25. Was case rafarred to medical examinar?	26. Place of Death (Check only ona)	
1☐Yas 2☒No	Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA	Other: 4☐Nursing Homa 5☒Rasidance 8☐Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Naturet 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined		M	1☐Yas 2☐No	
	28a. Placa of Injury - At homa, farm, straet, factory, office building, atc. (Specify)			28f. Locatlon (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒**Certifying Physician:** To tha bast of my knowledga, daath occurred at tha tima, date and place, and due to the causa(s) and mannar as stated.
2☐**Madical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, deta and piece, and dua to tha cause(s) and mannar statad.

29b. Signatura and titla of certifiar	29c. Licansa number	29d. Data signed (Month, Day, Year)
▶ EW Cole III MD	D16354	SEPT 23 1997

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Type, Print)

EW Cole III M.D. 900 Bestgate Rd Annapolis MD 21401

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
SEP 24 1997	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31345

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Eunice Virginia May

2. Dete of Deeth: Month September Dey 22 Yeer 1997

3. Time of Deeth: 10:22PM

4e. Facility Neme (If not institution, give street end number): St. Mary's Hospital

4b. City, Town, or Location of Deeth: Leonardtown

4c. County of Deeth: St. Mary's

Funeral Director

5. Sociel Security Number: 577-20-1997

6. Sex: 1☐M 2☒F

7. Age (In yrs. lest birthday): 75 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): Oct. 8, 1921

9. Birthplece (Stete or Foreign Country): Shenandoah Co, VA

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 6191 Delabrook Road

10f. Zip Code: 20659

10g. Citizen of Whet Country?: United States of America

11. Maritel Status: 1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:

14. Rece - Americen indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | Collega (1-4or 5+):

18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Walter C. Stine

18. Mother's Nema (First, Middle, Meiden Surneme): Mary E. Shell

19e. Informent's Name/Reletionship (Type, Print): Gloria Pritchard (daughter)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): PO BOX 1121, Mechanicsville MD 20659

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Gravel Springs Cemetery

Date: 9/26

20c. Location - City or Town, Steta: Star Tannery, Virginia

21. Signature of Funerel Servica Licensee: Karen W. Rowe

22. Neme end Address of Feciliity: Stover Funeral Home, Inc. 177 North Holliday St. Strasburg, VA 22657

Physician /Medical Examiner

23e. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. ACUTE RESPIRATORY FAILURE — 24 HRS

Due to (or es e consequence of): b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 12 YEARS

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated avents resulting in deeth) Lest

Due to (or es e consequenca of): c. CARCINOMA OF THE LUNGS — 9 MONTHS

Due to (or es e consequenca of): d. HYPERTENSION

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying ceusa given in Pert i.: PEPTIC ULCER DISEASE; OSTEOARTHRITIS

23b. Did tobacco use contribute to the cauee of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24e. Wes an eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Deta of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, streat, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physicien:** To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end mennar as stated. 2☐**Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the ceusa(s) end menner stated.

29b. Signature and title of certifier: [signature]

29c. License number: 017677

29d. Dete signed (Month, Dey, Yeer): SEPT 29, 1997

30. Neme end address of person who completed ceusa of daath (Item 23a) (Type, Print): GIL DE LOS REYES M.D. 21437 GREAT MILLS RD. LEXINGTON PARK, MD. 20653

State Registrar

31. Dete filed (Month, Day, Yeer): SEP 26 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

EUNICE MAY
Division of Vital Records, P.O. Box 68760,

97-5487-027
B.K.S
GREGORY B. MYRICK
Items:23a part I,27,28a-f per MEO G-752 10/20/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31346

Physician /Medical Examiner

1. Decadent's Name *(First, Middle, Last)*: GREGORY B. MYRICK

2. Dete of Death Month Day Year: SEPT. 26, 1997

3. Time of Death: 0208 AM

4a. Facility Name *(If not institution, give street end number)*: HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 219-70-4349

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Day, Year)*: JULY 12 1955

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7453 HICKORY LOG

10f. Zip Code: 21045

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Bleck, Whita, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest greda completed)*: Elementary/Secondery (0-12): 12th; College (1-4or 5+): 0

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CONSTRUCTION ENGINEER

16b. Kind of Business/Industry: FALLSTON UTILITIES

17. Father's Name *(First, Middle, Last)*: HARVEY V. MYRICK SR.

18. Mother's Nama *(First, Middle, Meiden Surnema)*: HAZEL M. WILLIAMS

19a. Informant's Name/Reletionship *(Type, Print)*: LYN MYRICK-CABASSA (SISTEER)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8001 JONES ROAD JESSUP, MARYLAND 20794

20e. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cametery, cremetory or other place)*: ANNAPOLIS MEM. GARDENS

Date: 9/30/97

20c. Location - City or Town, State: ANNAPOLIS, MD. 21401

21. Signatura of Funeral Service Licensee: Larry G. Reese

22. Name and Addrass of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not entar tha mode of dying, such as cardiac or raspiratory errast, shock, or heart failura. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence ol):

Sequentiellly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events rasulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☒ Could not be determined

28a. Date of Injury *(Month, Day Year)*: found: 9/26/97

28b. Time ol Injury: found:1:02 A M

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*: found: residence

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: 7453 Hickory Log Circle, Columbia, Maryland

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Exeminer:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Maynard Snellgrove M.D.

29c. Licanse number: O.C.M.E

29d. Date signed *(Month, Day, Yeer)*: SEPT. 26, 1997

30. Name and address ol person who completed cause ol death (Item 23a) (Type, Print): MARYANN D. KOROL 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Dey, Year)*: SEP 2 9 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31347

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES WESLEY McCARRIHER, SR.
2. Data of Death (Month, Day, Year): SEPT. 27, 1997
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): 118 JANELIN DRIVE
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 166-26-7125
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 08-07-1936
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 118 JANELIN DRIVE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: KOREA
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SALESMAN
16b. Kind of Business/Industry: COFFEE SUPPLIER

17. Father's Name (First, Middle, Last): WILLIAM McCARRIHER
18. Mother's Name (First, Middle, Maiden Surname): GENEIVE BRUNDER

19a. Informant's Name/Relationship (Type, Print): MARIANNE W. McCARRIHER (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 118 JANELIN DRIVE GELN BURNIE, MARYLAND 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CRESTLAWN MEMORIAL GARDEN | Date: 9-30 1997
20c. Location - City or Town, State: MARRIOTSVILLE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: THE SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cancer of Pharynx — 2 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rafat Y. Girgis
29c. License number: D31726
29d. Date signed (Month, Day, Year): 9/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rafat Y. Girgis 724 Maiden Choice LA Catonsville

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31348

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): William Gene MILLER
2. Dete of Deeth — Month: September Dey: 28 Yeer: 1997
3. Time of Deeth: 9:08 pm
4e. Feciity Neme (If not institution, give street end number): Franklin Square Hospital Center
4b. City, Town, or Location of Deeth: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Sociel Security Number: 179-32-9345
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. lest birthdey): 57 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Jan. 19, 1940
9. Birthpleee (Stete or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Joppa
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 408 Foster Knoll Dr.
10f. Zip Code: 21085
10g. Citizen of Whet Country?: USA
11. Meritei Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1959-1963
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, spacify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postman
16b. Kind of Business/Industry: US Postal Service
17. Father's Name (First, Middle, Last): Jordon A. Miller
18. Mother's Name (First, Middle, Meiden Surneme): Marion (unknown) Wirtz
19e. Informent's Neme/Reletionship (Type, Print): Mary C. Miller - Wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 408 Foster Knoll Dr., Joppa, Md. 21085
20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): R.A. Ferris & Co.
Dete: 9-30-97
20c. Location - City or Town, Stete: W. Chester, Pa.
21. Signeture of Funeral Service Licensee: Howard K. McComas III
22. Neme end Address of Feciility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in death): e. Metastatic Colon Carcinoma — 1½ Years

Due to (or as e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last:

b. Liver Metastasis — 1 Year

Due to (or es a consequence of):

c. Small Bowel Metastasis — 1 Year

Due to (or es e consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Noninsulin Dependent Diabetes Mellitus

Hypertension, Protein Malnutrition

Neutropenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ierm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: Michael Auerbach, MD

29c. License number: D33551

29d. Dete signed (Month, Dey, Yeer): September 28, 1997

30. Neme and address of peraon who completed cause of death (Item 23e) (Type, Print): Michael Auerbach M.D. 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 1 1997

32. Registrer's Signeture: [illegible]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31349

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Thersa Mehlmann

2. Date of Death: Month: October; Day: 02; Year: 1997

3. Time of Death: 07:55 AM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 160-10-4662

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-05-1914

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 302 Giles Street

10f. Zip Code: 21078

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Felix Mathews

18. Mother's Name (First, Middle, Maiden Surname): Mary Breen

19a. Informant's Name/Relationship (Type, Print): Mr. Joseph M. Mehlmann - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 #B, Seneca Way, Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Sepulchre Cemetery

Date: 10/4/97

20c. Location - City or Town, State: Cheltenham. PA

21. Signature of Funeral Service Licensee: William S. Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CA.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- A. Fib - NIDDM - MITRAL REGURG.
- DVT - HTN.
- CHF - AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Bianco MD

29c. License number: D42800

29d. Date signed (Month, Day, Year): 10/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type/Print): T. Bianco MD, UMC 314 S. Union Ave. Hbg, Md, 21078

State Registrar

31. Date filed (Month, Day, Year): OCT 3 1997

32. Registrar: Linda Lee Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Mehlmann, Mary

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31350

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: JOHN W. MORROW
2. Dete of Deeth Month Dey Yeer: SEPT. 30 1997
3. Time of Death: 1:20 PM
4a. Fecility Name *(If not institution, give street end number)*: 8543 NORTH BEND ROAD
4b. City, Town, or Location of Deeth: EASTON
4c. County of Deeth: TALBOT

Funeral Director

5. Sociel Security Number: 577-46-4715A
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 66 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAR. 4, 1931
9. Birthplece *(State or Foreign Country)*: IOWA

Usuel Residence of Decedent

10a. Stete: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 8543 NORTH BEND ROAD
10f. Zip Code: 21601
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Nevar Marriad 2☒Married 3☐Widowed 4☐Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highast grede completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MINISTER
16b. Kind of Business/Industry: RELIGION

17. Fether's Neme *(First, Middle, Last)*: ARTHUR A. MORROW
18. Mother's Neme *(First, Middle, Maiden Surneme)*: LOUISE WYLIE

19a. Informent's Name/Refetionship *(Type, Print)*: LYDIA N. MORROW/ WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8543 NORTH BEND RD., EASTON, MD 21601

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: OXFORD CEMETERY
Dete: 10-9
20c. Location - City or Town, Stete: OXFORD, MD

21. Signeture of Funerel Service Licensee: JOHN R. MERCER SR
22. Neme end Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet ceused the deeth. Do not entar tha moda of dying, such es cerdiac or raspiratory arrest, shock, or heert feilura. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in deeth)
e. BRAIN CANCER — 3 MONTHS

Due to (or es e consequence of):
b. PNEUMONIA — 1 WEEK

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an eutopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes cese referred to medicai exeminer? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Mennar of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Locetion *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and menner es steted.
2☐**Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: 10/1/97
29c. License number: D45725
29d. Date signed *(Month, Day, Year)*: 10/1/97

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): MICHELLE ONG, M.D., 606 DUTCHMAN'S LANE, EASTON, MD 21601

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 02 1997
32. Registrer's Signeture: Lucia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31351

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ann A. McCarthy
2. Date of Death Month Day Year: September 26, 1997
3. Time of Death: 1020
4a. Facility Name *(If not institution, give street and number)*: Medpointe
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-01-2672
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 2, 1914
9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1 Price Drive
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: n/a

17. Father's Name *(First, Middle, Last)*: George Turek
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Botwina

19a. Informant's Name/Relationship *(Type, Print)*: Theresa M. Ford - Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 858 Old Public Road - Hockessin, DE 19707

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cathedral Cemetery — Date: 9-30-1997
20c. Location - City or Town, State: Wilmington, Delaware

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 West Stockton Street - Elkton, MD 21921-5521

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular disease — 3 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D28339
29d. Date signed *(Month, Day, Year)*: Sept 30 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): LINDA FRENCH for Edward Marcus

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997
32. Registrar's Signature: ▶ Gina Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31352

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Melnick
2. Date of Death (Month, Day, Year): September 30, 1997
3. Time of Death: 1355
4a. Facility Name (If not institution, give street end number): Medpointe
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 206-14-9722
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 22, 1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 52 South Shore Road
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Designer
16b. Kind of Business/Industry: Electronic

17. Father's Name (First, Middle, Last): Michael Melnick
18. Mother's Name (First, Middle, Maiden Surname): Pauline Fetchen

19a. Informant's Name/Relationship (Type, Print): Thomas M. Melnick - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 515 Maple Hill Road - Havertown, PA 19083

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glenwood Memorial Garden
Date: 10-3 1997
20c. Location - City or Town, Stete: Broomall, PA

21. Signature of Funeral Service Licensee: Donna S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 West Stockton Street - Elkton, MD 21921-5521

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in daeth)
a. Anemia from Mechincal Valve Hemolysis — 6 months

Due to (or as a consequence of):
b. Peripheral Vascular Disease

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest

Due to (or as a consequance of):
c. Gangrene

Due to (or as a consequence of):
d. Diabetes Mellitis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case rafarred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only ona)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☑ **Certifying Physician**: To tha bast of my knowledga, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: James Ley
29c. License number: D43198
29d. Date signed (Month, Day, Year): 10/1/97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): James Ley, M.D. - 901 Warburton Road - Elkton, MD 21921

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julia Davidson-Rondelle

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hugh Edward Murray
2. Date of Death (Month, Day, Year): September 29, 1997
3. Time of Death: 21:50
4a. Facility Name (If not Institution, give street and number): Laurelwood Nursing Center
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 292-12-7251
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 29, 1924
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: NJ
10b. County: Burlington
10c. City, Town or Location: Burlington Twp.
10d. Inside City Limits: [X] 1 Yes 2 [ ] No
10e. Street and Number: 31 Walnut Drive
10f. Zip Code: 08016
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes [X] 2 [ ] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 10
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Ceramic Engineer
16b. Kind of Business/Industry: Ceramic Manufacturing

17. Father's Name (First, Middle, Last): Hugh Gerald Murray
18. Mother's Name (First, Middle, Maiden Surname): Mary Ellen Klein

19a. Informant's Name/Relationship (Type, Print): Edward J. Murray, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 217 Marlton Rd., Pilesgrove, NJ 08098

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Eglington Cemetery
Date: 10/3/97
20c. Location - City or Town, State: Clarksboro, NJ.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: 259 E. Main Street, Gee Funeral Home Elkton, Md. 21921

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Cholecystitis with Sepsis — 1 week
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Multiple CVA's, HBP, Deafness, Blindness, Demented
NIDDM, Hypoalbuminemia, Hemochromatosis
Renal Cysts, Pyuria

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: H. Farkas, MD
29c. License number: D 15314
29d. Date signed (Month, Day, Year): September 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H. Farkas, MD VNA/Northern Chesapeake Hospice, 111 High St, Elkton, MD 21921

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #14, MRS
10/1/97, Allegany County

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31354

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGINIA BRYL MARTZ

2. Date of Death Month Day Year: SEPTEMBER 29, 1997

3. Time of Death: 1650

4a. Facility Name (If not Institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-20-6901

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 11, 1917

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 515 MARYLAND STREET

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specity Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White ~~WHITE~~

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): WILLIAM REYNOLDS

16. Mother's Name (First, Middle, Maiden Surname): DELLA HILL

19a. Informant's Name/Relationship (Type, Print): DEBRA KEISTER/GRANDDAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 515 MARYLAND STREET - LAVALE, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HILLCREST BURIAL PARK

Date: 10/6/97

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Steven R. Upchurch

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: END STAGE RENAL DISEASE; HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Hilbert MD

29c. License number: D31875

29d. Date signed (Month, Day, Year): SEPTEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT HILBERT, MD - 902 SETON DR, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signature: Julia Strickler-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
MRS

DHMH 16 Rev 6/95

Amended Part II
Amended #23b, NLS,
10/1/97, Allegany County

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31355

Physician /Medical Examiner

1. Decedant's Nama *(First, Middla, Last)*: Freeda C. Mallow

2. Data of Death Month Day Yaar: SEPTEMBER 28,1997

3. Tima of Death: 1300

4a. Facility Nama *(If not institution, giva street and number)*: Sacred Heart Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-16-9202

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 11, 1920

9. Birthplaca *(Stata or Foreign Country)*: WV

Usual Residence of Dacedant

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Mount Savage

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13701 Abucevicz Road

10f. Zip Coda: 21545

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* white

15. Decedant's Educetion *(Specify only highast grade completed)*: Elamentary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa retired)*: Secretary/Accountant

16b. Kind of Businass/Industry: Textile

17. Fathar's Name *(First, Middla, Last)*: Freeman R. Kellar

18. Mothar's Nama *(First, Middla, Maiden Surnama)*: Effie C. Davis

19a. Informant's Name/Ralationship *(Type, Print)*: Sally E. Feeley-daughter

19b. Mailing Addrass *(Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: Port St. Lucie FL

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: Sunset Memorial Park

Data: 10/01

20c. Location - City or Town, Stata: Cumberland MD

21. Signature of Funaral Sarvice Licensee: James J Scarpelli

22. Nama and Address of Facility: Scarpelli Funeral Home Cumberland MD 21502

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceused tha daath. Do not enter tha moda of dying, such as cardiac or respiretory errest, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Between Onset and Deeth

Immediate Ceusa (Final disaase or conditlon resulting in daath)

a. Acute Renal failure — 3days

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiate ceusa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last

b. Probable Sepsis

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other algnificant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

Probable Sepsis

End Stage Rheumatoid Arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings evelleble prior to completion of causa of deeth? 1☐ Yas 2☐ No

25. Was cesa rafarred to medicel exeminar? 1☐ Yas 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Spacify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, daath occurred at tha time, dete end place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, deeth occurrad at tha tima, data and place, and dua to tha ceuse(s) end manner stated.

29b. Signature end title of certifier:

29c. License number: D33280

29d. Data signed *(Month, Day, Year)*: Sept 28, 1997

30. Nama and eddrass of person who completed ceusa of death (Item 23e) (Type, Print): Sunil Gupta M.D. 625 Kent Avenue #101 Cumberland, Md 21502

State Registrar

31. Dete filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signetura:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12
NLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31356

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN E. MOORE

2. Date of Death (Month, Day, Year): September 29 1997

3. Time of Death: 12:30 A.M.

4a. Facility Name (If not institution, give street end number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-20-6510

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jul 9, 1926

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 701 Frederick Street

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Christman

18. Mother's Name (First, Middle, Maiden Surneme): Lila (Shrout)

19a. Informant's Name/Relationship (Type, Print): Chris Carlile--friend

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 701 Frederick Street; Cumberland, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, crematory or other piece): Sunset Memorial Park

Date: 10/02

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)
e. PROBABLE SEPSIS — 1 WEEK

Due to (or as e consequence of):
b. VESICOVAGINAL FISTULA — 3 WEEKS

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Part fi. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the besis of examination end/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signature end title of certifier: ▶

29c. License number: D33280

29d. Date signed (Month, Dey, Year): Sept 29, 1997

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Sunil Gupta M.D. Johnson Heights Cumberland, MD 21502

State Registrar

31. Dete filed (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

EVELYN MOORE

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rodney L. Miller

2. Date of Death (Month, Day, Year): Oct 4 1997

3. Time of Death: 3:19PM

4a. Facility Name (If not institution, give street and number): 30 Beall's Lane

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 219-56-9889

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 22-Feb-49

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Frostburg

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 30 Beall's Lane

10f. Zip Code: 21532-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): 0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator

16b. Kind of Business/Industry: Tavern

17. Father's Name (First, Middle, Last): Harold H. Miller

18. Mother's Name (First, Middle, Maiden Surname): Mary E. Livingston

19a. Informant's Name/Relationship (Type, Print): Janet Wilson Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Frost Avenune Frostburg Maryland 21532-

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Frostburg Memorial Park

Date: 07-Oct-97

20c. Location - City or Town, State: Frostburg, Maryland

21. Signature of Funeral Service Licensee: John R. Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic alcohol abuse — 20 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D09157

29d. Date signed (Month, Day, Year): Oct 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Snow M.D. 124 w 3rd St Cumberland Md 21502

State Registrar

31. Date Filed (Month, Day, Year): OCT 06 1997

32. Registrar's Signature: John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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13

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31358

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Theresa Nguyen

2. Data of Death — Month: OCTOBER Day: 10, Year: 1997

3. Time of Death: 2:03 a.m.

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min. 5.

8. Date of Birth *(Month, Day, Year)*: Oct 10 1997

9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number

10f. Zip Code

10g. Citizan of What Country?

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Datas:

13. Was Dacadent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☐ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* Asain

15. Decadent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*

16b. Kind of Business/Industry

17. Father's Name *(First, Middle, Last)*: Nam Nguyen

18. Mother's Name *(First, Middle, Maiden Surname)*: Hanh Nguyen

19a. Informant's Name/Relationship *(Type, Print)*: Nam Nguyen father

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3 Noblewood Ct., Gaithersburg, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cramatory or other place)*: Gate of Heaven

Date: 10/13

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Will O. Dick

22. Name and Address of Facility: Hilton Funeral Home, Barnesville, MD 20838

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. prenature labr 20 1/2 weeks

Due to (or as a consequence of):

c. incompetent cervix

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dala and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deaih occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mark Seigel MD

29c. License number: D26246

29d. Date signed *(Month, Day, Year)*: 10 10 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark Seigel, MD 507 N. Frederick Ave Gaithersburg MD 20877

State Registrar

31. Date filed *(Month, Day, Year)*

32. Registrar's Signature ▶

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31359

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Franklin A. Novotny

2. Date of Death (Month, Day, Year): September 24, 1997

3. Time of Death: 6:30AM

4a. Facility Name (If not institution, give street and number): VA Maryland Health Care System

4b. City, Town, or Location of Death: Perry Point

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 136-34-0979

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2 14 1943

9. Birthplace (State or Foreign Country): Paulsboro, NJ

Usual Residence of Decedent

10a. State: NJ

10b. County: Salem

10c. City, Town or Location: Pennsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 97 Sanford Road

10f. Zip Code: 08070

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 8/78

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): U.S. Army

16b. Kind of Business/Industry: Military

17. Father's Name (First, Middle, Last): Martin Novotny

18. Mother's Name (First, Middle, Maiden Surname): Marie Clement

19a. Informant's Name/Relationship (Type, Print): Michael Quattrochi - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 97 Sanford Road, Pennsville, NJ 08070

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Joseph's Cemetery

Date: 10/2/97

20c. Location - City or Town, State: Swedesboro, NJ

21. Signature of Funeral Service Licensee: Frank C. Mayer, Jr. Frank C. Mayer Jr.

22. Name and Address of Facility: Spicer-Mullikin Funeral Homes,Inc. 1000 N. DuPont Pkwy,New Castle, DE 19720

To Be Completed by Funeral Director

FRANKLIN A. NOVOTNY
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart faitura. List only one causa on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Amyotrophic lateral sclerosis — 20 months

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings avelleble prior to completion of cause of daath? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Plece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Othar (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, date and place, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mannar statad.

29b. Signature and title of certifier: Melecia Santos M.D.

29c. License number: 151094-1

29d. Date signed (Month, Day, Year): September 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELECIA SANTOS, M.D., VA Maryland Health Care System, Perry Point, MD 21902

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN:
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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5+1VA

State Registrar

31. Date filed (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31360

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Yeer	3. Time of Death
TINA	L.	NIXON	September 26,1997	10:45 pm

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Memorial Hospital	Cumberland	Allegany

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-28-9352	1☐M 2☒F	71 Yrs.			May 16, 1926	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Allegany	Oldtown	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18502 Opessa Street SE	21555	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Former Employee	Grocery Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Seeders	Eula (Seeders)

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Steve Nixon-son	14047 Canal Road SE Cumberland MD 21502

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Davis Memorial Cemetery	09/29	Cumberland MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nicholas J Scarpelli	Scarpelli Funeral Home Cumberland MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in deeth)	e. Small Cell Carcinoma of Lung	Two Years
	Due to (or es a consequence of):	
Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in deeth) Lest	b.	
	Due to (or as e consequence of):	
	c.	
	Due to (or es a consequence of):	
	d.	

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of deeth?** 1☐Yes 2☐No 3☐Probably 4☑Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☑No	Hospitel: 1☑Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1☑**Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(s) end manner as steted. 2☐**Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end manner stated.

29b. Signature end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ Vik Poonai	D 36766	September 30,1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vik Poonai-955 Frededick Street-Cumberland, MD 21502

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
OCT 02 1997	▶ Julia Dickson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31361

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emmet John OBrien
2. Date of Death: Month: September Day: 30 Year: 1997
3. Time of Death: 4:20 PM
4a. Facility Name (If not institution, give street and number): Fallston General Hospital
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-12-6270
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 11, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Ineide City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 337 Carter Street
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yas, Giva Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elamantary/Secondary (0-12): 12 College (1-4or 5+): 4
16a. Dacedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Electronic Engineer
16b. Kind of Busineas/Industry: U.S Government

17. Father's Name (First, Middle, Last): John J. O'Brien
18. Mother's Name (First, Middle, Maiden Surname): Margaret Henlen Daily

19a. Intormant's Name/Relationship (Type, Print): Timothy F. O'Brien (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 1728 Carrs Mill Road, Fallston, Maryland 21047

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Placa of Disposition (Name of cametery, crematory or other place): Baker Cemetery
Date: 10/3/97
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licansee: Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disaase, or compilcations that causes the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailura. List only one cause on each lina.

Approximata Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in daath): a. NON SMALL CELL LUNG CANCER — 6 MONTHS

Due to (or as a consequance of):

Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consaquence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: DIABETES MELLITUS

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☑ No

24b. Were autopsy tindings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was case refarred to medical examinar? 1 ☐ Yes 2 ☑ No

26. Placa of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datermined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best ot my knowledge, death occurred at the tima, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis ot examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: [signature] MD
29c. License number: D31775
29d. Dete signed (Month, Day, Year): SEPTEMBER 30, 1997

30. Name and address of person who complatad causa of daath (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): OCT 1 - 1997
32. Registrar's Signature: [signature] Candace Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31362

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Reginald Calvert Orem

2. Deta of Deeth: Month Oct. Day 5, Yeer 1997

3. Time of Death: 3:07 am

4a. Facility Name (If not institution, give street and number): Emergency Room Dorchester General Hospital

4b. City, Town, or Location of Deeth: Cambridge

4c. County of Deeth: Dorchester

Funeral Director

5. Social Security Number: 212-05-3146

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): Nov. 29, 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 209 High St.

10f. Zip Code: 21613

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Eduestion (Specify only highest grede completed): Elementery/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Newspaper Editor

16b. Kind of Business/Industry: Journalism

17. Father's Name (First, Middle, Last): Earle W. Orem

18. Mother's Name (First, Middle, Malden Surneme): Birdsel Drain

19a. Informent's Neme/Relationship (Type, Print): Leah O. Gore/Daughter

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 209 High St., Cambridge, MD 21613

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca): Grace Episc. Ch. Cem.

Dete: 10-9-97

20c. Locetion - City or Town, Stete: Taylors Island, MD

21. Signeture of Funeral Service Licensee: Kathleen Curran Bromwell

22. Neme end Address of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Ceusa (Final disease or condition resulting in deeth):

e. Cardiopulmonary arrest — 3-4 hrs.

Due to (or es e consequence of):

b. CHF. — years

Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Last

Due to (or es e consequence of):

c. CVA. — years

Due to (or es e consequence of):

d. dementia. — year.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Ahmed Nawaz

29c. License number: D0050987

29d. Dete signed (Month, Day, Yeer): 10-5-97.

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): AHMED NAWAZ 105 Aurora Street Cambridge MD 21613

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT - 9 1997

32. Registrar's Signeture: Julia Strucker-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Orem, Reginald

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Robert Puffenbarger

2. Data of Death Month: OCTOBER Day: 2, Year: 1997

3. Time of Death: 6:09 AM

4a. Facility Name (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 219-03-9053

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 16 1922

9. Birthplace (State or Foreign Country): WVA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Charles

10c. City, Town or Location: Indian Head

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3980 Smallwood Church Rd.

10f. Zip Code: 20640

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Raca - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Leading Man Grounds Matience Truck Driver

16b. Kind of Business/Industry: N.O.S. U.S. Government

17. Father's Name (First, Middle, Last): James R. Puffenbarger

18. Mother's Name (First, Middle, Maiden Surname): Sallie Belle Ryder Puffenbarger

19a. Informant's Name/Relationship (Type, Print): Wife Betty Lee Puffenbarger

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20640 3980 Smallwood Church Rd. Indian Head, MD

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): Nanjemoy Church Cem.

Date: 10/4/97

20c. Location - City or Town, State: Nanjemoy, MD

21. Signature of Funeral Service Licensee: David C. Echols MO0945

22. Nama and Address of Facility: AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata, MD 20646

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atrial flutter

Due to (or as a consequence of):

b. Coronary Artery disease

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in daath) Last

Due to (or as a consequence of):

c. Arteriosclerosis

Due to (or as a consequence of):

d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Sepsis, anemia, Dehydration Renal insufficiency, angina ilius, aortic aneurysm repair

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, straet, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-08370

29d. Date signed (Month, Day, Year): 10/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL PRITCHETT M.D. 118 LAGRANGE AVENUE P.O. BOX 1317 LAPLATA MD. 20646

State Registrar

31. Date filed (Month, Day, Year): OCT 0 3 1997

32. Registrar's Signature: Julia Dawson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: Tha law requiras that the death certificata be executed within 24 hours after death.

To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

WILLIAM PUFFENBARGER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31364

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LLEWELLYN E. PRICE, JR.

2. Date of Death: Month: October; Day: 1; Year: 1997

3. Time of Death: 4:01pm

4a. Facility Name *(If not institution, giva street and number)*: Physicians Memorial Hospital

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 216-50-7901

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: April 8, 1948

9. Birthplaca *(Stata or Foraign Country)*: Washington DC

Usual Rasidanca of Decedant

10e. State: Maryland

10b. County: Charles

10c. City, Town or Location: Waldorf

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 2904 Jackson Court

10f. Zip Coda: 20602

10g. Citizan of What Country?: USA

11. Maritel Status: 1☐ Nevar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decadant Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Meat Cutter

16b. Kind of Businass/Industry: Giant Food

17. Fathar's Name *(First, Middla, Last)*: Llewellyn E. Price, Sr.

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Mary L. McDonald

19e. Informant's Name/Relationship *(Type, Print)*: Roberta Price - Wife

19b. Mailing Address *(Street and Number or Rurel Routa Number, City or Town, Stata, Zip Code)*: 2904 Jackson Court, Waldorf, MD 20602

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nema of cematery, cremetory or othar pleca)*: Huntt Crematory

Dete: 10-4-97

20c. Location - City or Town, Steta: Waldorf, Maryland

21. Signature of Funaral Sarvica Licansee: Shannon W. Ramirez

Shannon W. Ramirez M00798

22. Nama and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona causa *on* aach line.

Approximata Intarval Batwaen Onsat and Death

Immadiata Ceusa (Final disaasa or condition rasulting in death)

a. Arteriosclerotic Cardiovascular Disease — years

Dua to (or as a consaquanca of):

b. Diabetes Mellitus

Saquantially list conditions, if any, laading to immadiate cause. Enter Undarlying Causa (Disease or Injury that initiatad avants rasulting in daath) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa referrad to medical exeminar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowladge, daath occurrad at the time, dete and placa, and dua to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or invastigation, in my opinion, daath occurrad at tha tima, data and pleca, and dua to tha causa(s) and manner stated.

29b. Signature and title of cartifiar: HM Haft

29c. Licansa number: D-27348

29d. Date signed *(Month, Day, Yaar)*: 10/2/97

30. Nama and addrass of parson who complatad causa of death (Item 23e) (Type, Print): Howard Haft, MD 700 Olde Line Center, Suite 100, Waldorf, Maryland 20602

State Registrar

31. Date filed *(Month, Day, Yaar)*: OCT 06 1997

32. Registrar's Signatura: Julia Strickson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Price Jr, Llewellyn E
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31365

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace Puskas

2. Date of Death Month / Day / Year: September 21 1997

3. Time of Death: 18:34

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 147-24-3386

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 12 1908

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 149 Island View Drive

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: X

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Tony Griesler

18. Mother's Name *(First, Middle, Maiden Surname)*:

19a. Informant's Name/Relationship *(Type, Print)*: Jane Richardson/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 149 Island View Dr. Annapolis, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Josephs Cemetery / Date:

20c. Location - City or Town, State: New Jersey

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Sepsis — 2 days

Due to (or as a consequence of):
b. Hip Fracture — 2 weeks

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cerebrovascular accident — old

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D40519

29d. Date signed *(Month, Day, Year)*: 9/23/97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mirza M. Nusairee, Md, 7845 Oakwood Rd. Glen Burnie, Maryland 21108

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 24 1997

32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31366

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elisabeth Frida Pryma

2. Date of Death Month Day Year: September 26, 1997

3. Time of Death: 11:20 Am

4a. Facility Name *(If not institution, give street and number)*: 309 South Parke Street Apt 12-A

4b. City, Town, or Location of Death: Aberdeen

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 247-60-0083

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 13, 1927

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residance of Dacedant

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 309 South Parke Street Apt. A-12

10f. Zip Coda: 21001

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12; Collaga (1-4or 5+): 2

16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Businass/Industry: Nursing

17. Father's Nama *(First, Middla, Last)*: Ernst Liebenberg

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Martha Huettrog

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Evelyn Owens (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 426 Elkton, Maryland 21921

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cematery, crematory or othar place)*: Harford Memorial Gardens

Data: 9/30/97

20c. Location - City or Town, Stata: Aberdeen, Maryland

21. Signature of Funaral Service Licensee: Kirsten Amey Unglesbee

22. Nama and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List *only one* causa *on* aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Coronary Artery Disease — 8 yrs.

Dua to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa raferrad to medical exeminar? 1☐ Yas 2☑ No

28. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Other: 4☐ Nursing Homa 5☑ Residence 8☐ Othar *(Specify)*

27. Mannar of Death: 1☐ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: William MD

29c. Licansa number: D 32609

29d. Data signed *(Month, Day, Year)*: 9/26/97

30. Name and addrass of parson who completed causa of death (Item 23a) (Type, Print): Kamnuden Mukherjee MD 703 Revolution St Havre De Grace MD 21078

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signatura: Linda Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31367

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Delbert H Peterman

2. Deta of Death — Month: September Day: 30 Yaar: 1997

3. Time of Death: 1 44 Am

4a. Facility Neme (If not institution, giva street and number): Harford Memorial Hospital

4b. City, Town, or Location of Deeth: Havre de Grace

4c. County of Deeth: Harford

Funeral Director

5. Social Security Number: 716-01-6214

6. Sex: 1☒ M 2☐ F

7. Aga (In yrs. last birthday): 88 Yrs.

If Under 1 Yaer — Months: Deys:

If Under 24 Hrs. — Hours: Min.:

8. Deta of Birth (Month, Day, Year): Mar 15, 1909

9. Birthplaca (Stete or Foraign Country): Maryland

Usual Rasidanca of Dacadant

10a. Stata: MD

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 401 Pearl St.

10f. Zip Coda: 21911

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yeer or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: White

15. Dacedant's Education (Specify only highast grade compliatad)

Elamantary/Secondary (0-12): unknown

Collaga (1-4or 5+):

16a. Dacadant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired): Shop worker

16b. Kind of Businass/Industry: Railroad

17. Fethar's Nama (First, Middla, Last): Robert J. Peterman

18. Mothar's Nama (First, Middle, Meidan Sumama): Ida Rose

19a. Informant's Name/Ralationship (Typa, Print): Nancy Montgomery, Stepdaughter

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): P O Box 274 401 Pearl St. Rising Sun MD 21911

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Brookview Cemetery

Data: Oct 3 1997

20c. Location - City or Town, Stete: Rising Sun MD

21. Signature of Funeral Service Licensee: Richard L. Foarde

22. Nama and Address of Facility: R. T. Foard Funeral Home, PA 111 S Queen St. Rising Sun MD 21911

Physician /Medical Examiner

23a. Entar1. Entar tha disaasa, or complications that caused the daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Between Onset and Death

Immadiata Causa (Final disaase or condition rasulting in daath) a. Pneumonia

Dua to (or as a consequance of):

Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Diseasa or injury that initiated evants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as e consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.

-CHF -A. FIB

-HYPOGLYCEMIC EPISODE -COPD.

-THROMBOCYTOPENIA

23b. **Did tobacco usa contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death (Chack only ona) Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar: T. Bounds MD.

29c. Licansa number: D42800

29d. Date signed (Month, Day, Year): 9/30/97

30. Nama and address of person who complatad causa of daath (Itam 23a) (Type, Print): T. Bounds 3185 Union Ave., Hdg, Md 21078

State Registrar

31. Data filed (Month, Day, Year): OCT 01 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Delbert Hamilton Peterman

14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31368

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Della Hubble Potts
2. Dete of Deeth Month Dey Yeer: October 6, 1997
3. Time of Death: 0805 A
4a. Feciility Neme *(If not institution, give street and number)*: 602 Elkton Boulevard
4b. City, Town, or Location of Deeth: Elkton
4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 212-22-2096
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: August 19, 1919
9. Birthplece *(State or Foreign Country)*: Virginia

Usuel Residence of Decedent

10e. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 602 Elkton Boulevard
10f. Zip Code: 21921
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry:

17. Father's Neme *(First, Middle, Last)*: Aaron L. Hubble
18. Mother's Neme *(First, Middle, Meiden Surname)*: Katie May White

19e. Informent's Neme/Reletionship *(Type, Print)*: Bruce L. Speck/friend
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 220 Park Circle, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Gilpin Manor Memorial Park
Dete: 10/7 1997
20c. Location - City or Town, Stete: Elkton, Maryland

21. Signeture of Funeral Servica Licensee: Dawed S. Hicks
22. Neme and Address of Feciility: Hicks Home for Funerals, P.A. 103 West Stockton St., Elkton, Maryland 21921

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Pneumonia — 1 wk

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet Initieted events resulting in deeth) Lest:
b. chronic obstructive lung disease
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other signiffcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☐ No

28. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physicfan:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted.

29b. Signeture end titie of certifier:
29c. License number: D44102
29d. Dete signed *(Month, Dey, Yeer)*: 10/6/97

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): William F. Renzulli, M.D. 901 Warburton Road, Elkton, Maryland 21921

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 07 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

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8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MYRTLE SMITH PITTS

2. Date of Death: Month: October Day: 3 Year: 1997

3. Time of Death: 1040

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 224-60-8185

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/10/42

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: VA

10b. County: Accomack

10c. City, Town or Location: Parksley

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 26506 Kinsey Drive

10f. Zip Code: 23421

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer

16b. Kind of Business/Industry: Poultry

17. Father's Name (First, Middle, Last): James T. Chandler

18. Mother's Name (First, Middle, Maiden Surname): Mary G. Smith

19a. Informant's Name/Relationship (Type, Print): Terrence Smith /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 351, Mappsville, VA 23407

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wharton's Cemetery

Date: 10/11/97

20c. Location - City or Town, State: Parksley, VA

21. Signature of Funeral Service Licensee: James T. Cooper Jr.

22. Name and Address of Facility: COOPER & HUMBLES FUNERAL CO., INC. P. O. Box 176, Accomac, VA 23301

224-60-8185

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or liver failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cardiac failure

Due to (or as a consequence of): b. Fluid overload

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c. Renal failure

Due to (or as a consequence of): d. Nephrotic Syndrome

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Diabetes Mellitus, Hemolytic Uremic Syndrome, Pancytopenia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: MD-048221

29d. Date signed (Month, Day, Year): 10/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julio De Pena 262 Tilghman Rd. Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): OCT 07 1997

32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Myrtle Pitts

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31370

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THEO MACHEN PETERSON
2. Date of Death Month Day Year: OCTOBER 5, 1997
3. Time of Death: 0255 am
4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 220-03-4706
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 18, 1919
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: St. Leonard
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4009 Lloyd Bowen Road
10f. Zip Code: 20685
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Hervey Gilbert Machen
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Eliza Middleton

19a. Informant's Name/Relationship *(Type, Print)*: Joyce M. Peterson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 719 Maury Street, Memphis, Tennessee 38107

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory — Date: 10/6/97
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Charles F. Bell
22. Name and Address of Facility: Rausch Funeral Home, P.A. 4405 Broomes Island Rd., Port Republic, MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Small cell lung Carcinoma c Metastasis — 12 mos

Due to (or as a consequence of):
b. COPD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Diabetes

Due to (or as a consequence of):
d. Hypertension

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ J. Michael Bowling
29c. License number: D79820
29d. Date signed *(Month, Day, Year)*: 10-5-97 10:22am

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 100 Hospital Dr. Suite 204, Prince Frederick MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 06 1997
32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-5610-033
jhm
JANON
BRYANT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31371

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janon B Robinson

2. Date of Death (Month, Day, Year): SEPTEMBER 30, 1997

3. Time of Death: 21:25 PM

4a. Facility Name (If not institution, give street and number): 801 MAURY AVENUE APARTMENT 102

4b. City, Town, or Location of Death: OXON HILL

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 248-21-6127

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 28, 1964

9. Birthplace (State or Foreign Country): Charleston S.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 801 Maury Ave. Apt 102

10f. Zip Code: 20745

10g. Citizen of What Country? USA

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cosmetologist

16b. Kind of Business/Industry: Hair Salon

17. Father's Name (First, Middle, Last): Andrew Powell

18. Mother's Name (First, Middle, Maiden Surname): Sheila Bryant

19a. Informant's Name/Relationship (Type, Print): Philip Talley / Relative

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9413 Surratts Manor Dr. Clinton MD 20735

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery | Date: Oct. 8, 1997

20c. Location - City or Town, State: Clinton Maryland

21. Signature of Funeral Service Licensee: Lloyd

22. Name and Address of Facility: Adams F. Home. Aquasco Maryland 20608

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MULTIPLE STABS AND CUTTING WOUNDS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 9 30 97

28b. Time of Injury: ~ 1830 (M)

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred: SUBJ GOT STABBED AND CUT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 80 MAURY RD PRINCE GEORGES

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Dr. Gowdy

29c. License number: OCME

29d. Date signed (Month, Day, Year): OCTOBER 01, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARJORIE D. GOWDY, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 06 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31372

GEORGE ROBINSON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE FRANKLIN ROBINSON
2. Date of Death (Month, Day, Year): SEPTEMBER 23, 1997
3. Time of Death: 7:55 PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL ASSN
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 220-07-7018
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 29, 1918
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 508 JOY CIRCLE
10f. Zip Code: 21061
10g. Citizen of Whet Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): M.V.A.
16b. Kind of Business/Industry: STATE OF MARYLAND
17. Father's Name (First, Middle, Last): JAMES FRANK ROBINSON
18. Mother's Neme (First, Middle, Meiden Surneme): BOZENA MACH
19a. Informant's Name/Relationship (Type, Print) (NIECE): JEANNETTE COLEY-JACKSON
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 94 FOXWELL BEND ROAD, GLEN BURNIE, MD. 21061
20a. Method of Disposition: 1☐ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☒ Other (Specify) ENTOMBMENT
20b. Place of Disposition (Neme of cemetery, cremetory or other place): CEDAR HILL CEMETERY
Date: 9/26/97
20c. Location - City or Town, State: BROOKLYN PARK, MD.
21. Signature of Funeral Service Licensee:
22. Name end Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W. GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one ceuse on eech line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. SEPSIS

Due to (or es e consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest
Due to (or as a consequence of):
c. COLON CANCER

Due to (or as e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CARDIOMYOPATHY
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Deeth: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end manner stated.
29b. Signature and title of certifier: MD
29c. License number: D43957
29d. Date signed (Month, Day, Year): September 23 1997
30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print): AYDIN ORETUNJI, 301 HOSPITAL DRIVE, GLEN BURNIE, MD. 21061

State Registrar

31. Date filed (Month, Dey, Year): SEP 25 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31373

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSALIE S. RUSS
2. Date of Death (Month, Day, Year): SEPTEMBER 28, 1997
3. Time of Death: 1850
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-07-7379
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 12, 1922
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 29 PARK LANE, HYDE PARK
10f. Zip Code: 21601
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): MERREL H. SPENCE
18. Mother's Name (First, Middle, Maiden Surname): CARRIE MARIE GREENLY

19a. Informant's Name/Relationship (Type, Print): R. MERREL RUSS/ SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28000 WOODS RD., EASTON, MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, L.L.C. | Date: 10-1
20c. Location - City or Town, State: CHESTER, MD

21. Signature of Funeral Service Licensee: M. E. Newnam III CFSP
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLE TRAUMA	9 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. AUTO ACCIDENT	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CARCINOMA COLON

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☑ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☑ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year): 9-20-97
28b. Time of Injury: 1849 M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: DRIVER 2 VEHICLE COLLISION
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): RT. 322 at Glebe Rd.
28f. Location (Street and Number or Rural Route Number, City or Town, State): EASTON, MD

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John G Bulkley D.M.E.
29c. License number: D03599
29d. Date signed (Month, Day, Year): 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Bulkley, M.D. 108 PINE BLUFF RD SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): OCT 01 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

97 31374

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ida Virginia Ray
2. DATE OF DEATH (Month, Day, Year): Sep 30, 1997
3. TIME OF DEATH: 8:40 pm M
4. SOCIAL SECURITY NUMBER: 215-26-9546
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct 7, 1930
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Allegany County Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12 Blue Jay Drive
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Willis H. Blizzard
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha E. (McConnell)
19a. INFORMANT'S NAME (Type/Print): Linda Sullivan-daughter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 319 Ridgeley WV 26753
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | DATE: 10/03
20c. LOCATION — City or Town, State: Cumberland MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Nicholas L Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home Cumberland MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, (or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Bilateral Aspiration pneumonia	5 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Multiple Sclerosis	20 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Basal ganglion disorder.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: V. A. Ranjithan
29c. LICENSE NUMBER: D19750
29d. DATE SIGNED (Month, Day, Year): ▶ Oct. 1, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V.A. Ranjithan 517 Oldtown Road Cumberland MD 21502
31. DATE FILED (Month, Day, Year): OCT 01 1997
32. REGISTRAR'S SIGNATURE: Jake Davidson-Kendall

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4 Feb

OHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31375

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Horace Frank Ruark
2. Date of Death (Month, Day, Year): September 28, 1997
3. Time of Death: 11:10 PM
4a. Facility Name (If not institution, give street and number): Salisbury Center: Genesis ElderCare
4b. City, Town, or Location of Death: Salisbury, MD
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 213-24-1385
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07/31/1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Somerset
10c. City, Town or Location: Marion
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 27079 Ream Lane
10f. Zip Code: 21838
10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Lumber

17. Father's Name (First, Middle, Last): Frank Horace Ruark
18. Mother's Name (First, Middle, Maiden Surname): Vivian Ross

19a. Informant's Name/Relationship (Type, Print): Alden Ruark/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27079 Ream Lane, Marion, Md. 21838

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Quinton Cemetery
Date: 10/02/97
20c. Location - City or Town, State: Pocomoke City, Md.

21. Signature of Funeral Service Licensee: [signature] M00295
22. Name and Address of Facility: Hinman Funeral Home, 11673 Somerset Avenue, Princess Anne, Md. 21853

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sudden Death, Suspect Arrhythmia
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
History Seizure Disorder, Alcoholism, Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 39813
29d. Date signed (Month, Day, Year): 9/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael R. Atkins, M.D. 1104 Healthway Dr., Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): OCT - 3 1997
32. Registrar's Signature: [signature] Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31376

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILMA SOUDERS
2. Date of Death (Month, Day, Year): October 2, 1997
3. Time of Death: 5:15a.m.
4a. Facility Name *(If not institution, give street and number)*: 2007 B Wedgewood Place
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-03-3455
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 28, 1909
9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10e. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2007B Wedgewood place
10f. Zip Code: 20602
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator
18b. Kind of Business/Industry: DC Government

17. Father's Name *(First, Middle, Last)*: George Irving Scrivener
18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Mabel Lake

19a. Informant's Name/Relationship *(Type, Print)*: George L. Souders - Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2007-B Wedgewood Place, Waldorf, MD 20602

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans' Cem.
Date: 10-6-97
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: Mark G. Brohawn M00053
22. Name and Address of Facility: Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Obstructive Pulmonary Disease — 4 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Mathur
29c. License number: D28352
29d. Date signed *(Month, Day, Year)*: October 2, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, M.D. - P. O. Box 2729, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 06 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31377

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVA ANNA SEMMLER
2. Date of Death (Month, Day, Year): SEPTEMBER 21, 1997
3. Time of Death: 2:30 AM
4a. Facility Name *(If not institution, give street and number)*: 914 TIMBER RIDGE DRIVE
4b. City, Town, or Location of Death: HANOVER
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 217-24-3215
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN. 10, 1913
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: HANOVER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 914 TIMBER RIDGE DRIVE
10f. Zip Code: 21076
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: CHARLES AMEND
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA EDELMAN

19a. Informant's Name/Relationship *(Type, Print)*: CHARLES G. SEMMLER (HUSBAND)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 914 TIMBER RIDGE DRIVE, HANOVER, MD. 21076

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MEADOWRIDGE MEMORIAL PARK — Date: 9/24/97
20c. Location - City or Town, State: ELKRIDGE, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute respiratory failure.

Due to (or as a consequence of):
b. Pneumonia.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Advanced Dementia Alzheimers.

Due to (or as a consequence of):
d. ASCVD.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Sev. osteoarthritis.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature].
29c. License number: D30568
29d. Date signed *(Month, Day, Year)*: 9-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SHOBHA D. REDDY 7845 OAKWOOD RD. STE 204 Glen Burnie, Md. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 23 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31378

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Edward Scarlett, JR.

2. Data of Death Month Day Yeer: September 21 1997

3. Time of Death: 12:05 PM

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-10-2438

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 01,1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1915 Whitehall Road

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ramsay/Scarlett Co., Inc.

16b. Kind of Business/Industry: Shipping

17. Father's Name *(First, Middle, Last)*: Charles E. Scarlett

18. Mother's Name *(First, Middle, Maiden Surname)*: Emily Thorpe Patterson

19a. Informant's Name/Relationship *(Type, Print)*: Marie D. Scarlett / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1915 Whitehall Rd. Annapolis, Maryland 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Crematory

Date: 09/22/1997

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. renal failure

Due to (or as a consequence of):

b. dehydration

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D-18804

29d. Date signed *(Month, Day, Year)*: 9/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barbara T Furlow MD 705 Hillridge Ct Annapolis Md 21401

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 25 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31379

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rachel Alice Green Singleton

2. Date of Death Month Day Year: September 27, 1997

3. Time of Death: 4:55 AM

4a. Facility Name *(If not institution, give street and number)*: Citizens Nursing Home

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 166-05-7499

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11-24-1908

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 100 Revolution Street

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: John Creswell

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Miller

19a. Informant's Name/Relationship *(Type, Print)*: Miss Dorothy L. Walker

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 700 S. Washington St., Havre de Grace, MD21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lawn Croft Cemetery

Date: 10/1/97

20c. Location - City or Town, State: Linwood, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Diffuse encephalopathy — Two weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetes Mellitus

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Craig Mirza A-Baig

29c. License number: D43115

29d. Date signed *(Month, Day, Year)*: 9-25-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 622 S. Union Avenue, Havre de Grace, MD 21078

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 29 1997

32. Registrar's Signature: [signature] Lindsay Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Singleton, Rachel A.

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31380

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Peter Sadera
2. Date of Death: Month: October Day: 2, Year: 1997
3. Time of Death: 4:00 a.m.
4a. Facility Name (If not institution, give street and number): 99 Mt. Royal Avenue
4b. City, Town, or Location of Death: Aberdeen
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 108-07-8592
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 30, 1907
9. Birthplace (State or Foreign Country): Czechoslovkia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 99 Mt. Royal Avenue
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self employed
16b. Kind of Business/Industry: Building Contractor

17. Father's Name (First, Middle, Last): Baltazar Sadera
18. Mother's Name (First, Middle, Maiden Surname): Frankeska DuBua

19a. Informant's Name/Relationship (Type, Print): Mrs. Sophia A. Sadera (Spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 99 Mt. Royal Avenue, Aberdeen, Maryland 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens — Date: 10/4/97
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Gary L. DiGiovanni
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Respiratory failure — 1 wk

Due to (or as a consequence of):
b. Metastatic carcinoma of esophagus — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic vascular disease
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D14544
29d. Date signed (Month, Day, Year): Oct 2, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IAN D. SOMERVILLE 400 LEWIS ST. HAVRE DE GRACE MD 21078

State Registrar

31. Date filed (Month, Day, Year): OCT 3 1997
32. Registrar's Signature: [illegible]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

RKD
97-5634-005
PAUL
SHAVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31381

Physician /Medical Examiner

1. Decadant's Nama *(First, Middle, Last)*: FREDERICK PAUL SHAVER
2. Data of Daath Month Day Yaar: SEPTEMBER 30, 1997
3. Tima of Death: 2:32P.M.
4a. Facility Nama *(If not institution, give street and number)*: 9201 NOTTINGWOOD ROAD
4b. City, Town, or Locatlon of Deeth: WHITE MARSH
4c. County of Deeth: BALTIMORE

Funeral Director

5. Social Sacurity Number: 218-42-5168
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 51 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Yaar)*: Feb. 23, 1946
9. Birthplaca *(Stata or Foraign Country)*: West Virginia

Usuel Rasidanca of Dacadant

10a. Stata: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☐Yas 2☒No
10e. Street and Number: 9201 Nottingwood Rd.
10f. Zip Coda: 21237
10g. Citizan of What Country?: USA

11. Marital Status: 1☐Never Marriad 2☐Married 3☐Widowad 4☒Divorcad
12. Was Dacedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*
14. Rece - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Sacondary (0-12); Collaga (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: President
16b. Kind of Businass/Industry: Savings and Loan Assoc.

17. Fathar's Nama *(First, Middla, Last)*: James Malcolm Shaver
18. Mothar's Nama *(First, Middla, Maidan Surname)*: Dolores Edith Watts

19a. Informant's Name/Raletionship *(Type, Print)*: James M. Shaver - father
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1404 Shirley Ave., Bel Air, Md. 21015

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: Harford Memorial Gardens
Data: 10-4-97
20c. Location - City or Town, State: Aldino, Md.

21. Signatura of Funaral Sarvica Licansaa: Charles A. Smye Jr.
22. Name and Addrass of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Intarval Batwaan Onsat and Deeth

Immadiata Cause (Final disaasa or condition rasulting in daath): a. Arteriosclerotic Cardiovascular Disease

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiatad avants rasulting in daath) Last:
Due to (or as a consequanca of):
b.
Due to (or as a consequanca of):
c.
Due to (or as a consaquanca of):
d.

Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I.: Multiple Sclerosis

23b. Did tobacco usa contributa to the cause of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? INSPECTION 1☐Yas 2☒No
24b. Were autopsy findings availabla prior to completion of cause of death? 1☐Yas 2☐No

25. Was casa rafarrad to madical examinar? 1☒Yas 2☐No
26. Place of Deeth *(Check only one)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA; Othar: 4☐Nursing Homa 5☒Rasidance 6☐Other *(Spacify)*
27. Mannar of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending Investigation 6☐Could not be datarmined
28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐Yas 2☐No
28d. Dascribe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, offica building, atc. *(Specify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☐**Certifying Physician**: To the best of my knowledga, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☒**Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.
29b. Signatura and title of certifier: J. Laron Locke M.D.
29c. Licansa number: O.C.M.E.
29d. Dete signed *(Month, Day, Yaar)*: OCTOBER 2, 1997
30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 3 1997
32. Registrar's Signatura: Debbie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KATHRYN SCHOOLFIELD

2. Date of Death Month: SEPTEMBER Day: 29 Year: 1997

3. Time of Death: 14:22

4a. Facility Name (If not Institution, give street and number): SINAI HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 213-6265

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-08-27

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Worcester

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 600 4th Street

10f. Zip Code: 21851

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife

16b. Kind of Business/Industry: Home Engineer

17. Father's Name (First, Middle, Last): Elton Wise

18. Mother's Name (First, Middle, Maiden Surname): Blanche Core

19a. Informant's Name/Relationship (Type, Print): Elaine Wise (niece)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1718 Dutch Villiage Dr.,Landover,Maryland 20785

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hall's Hill Cemetery

Date: 10/04/97

20c. Location - City or Town, State: Pocomoke,Maryland

21. Signature of Funeral Service Licensee: John A. Prince

22. Name end Address of Facility: Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. OVARIAN CARCINOMA - STAGE IIc	TWO YEARS
	Due to (or as a consequence of):	
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: ASTHMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyatcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Brian Rayson MD

29c. License number: D0051053

29d. Date signed (Month, Day, Year): SEPTEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. BRIAN RAYSON, MD SINAI HOSPITAL OF BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): OCT 03 1997

32. Registrar's Signature: Lia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31383

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth P. Snider

2. Data of Daath — Month: OCTOBER; Day: 3; Year: 1997

3. Time of Death: 11:25 am

4a. Facility Nama (If not institution, give street and number): MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 212-24-0516

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthdey): 77 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Data of Birth (Month, Day, Year): Jul 18, 1920

9. Birthplace (Stete or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 13207 Moore's Hollow RD SE

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12; Collega (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middla, Last): Adam Stafford

18. Mother's Name (First, Middle, Meiden Surneme): Myrtha (Rice)

19a. Informant's Name/Ralationship (Type, Print): Homer R. Snider-husband

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 13207 Moore's Hollow RD SE Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Mt. Herman Cemetery

Date: 10/06

20c. Location - City or Town, Stata: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home Cumberland MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC CARCINOMA OF LUNG — 5 YEARS

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the ceuse of death?** 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceusa of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 33280

29d. Date signed (Month, Dey, Year): Oct 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SUNIL GUPTA, JOHNSON HEIGHTS, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): OCT 07 1997

32. Registrar's Signature:

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

RUTH SNIDER 212-24-0516

5 MLS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31384

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Joyce Maurine Tidwell

2. Date of Deeth Month Dey Year: September 17, 1997

3. Time of Death: 2:00 am

4e. Fecility Neme *(If not Institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Deeth: Annapolis

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 462-28-3640

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 71 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: July 2, 1926

9. Birthplace *(State or Foreign Country)*: Texas

Usual Residence of Decedent

10a. Stete: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3023 Arundel on the Bay

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12+ | College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Assistant

16b. Kind of Business/Industry: U.S. Air Force

17. Fether's Name *(First, Middle, Lest)*: Robert Floyd Martin

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruby (unknown)

19a. Informant's Name/Reletionship *(Type, Print)*: Steve Tidwell/son

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1429 Jarrold Place, Crofton, MD 21114

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory

Date: Sept 17 1997

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Service Licensee: James E Barranco

22. Neme end Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Cerebrovascular Accident — 2 days

Due to (or as a consequence of): b. Sepsis — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: R. Scott Eden, MD

29c. License number: D30701

29d. Date signed *(Month, Day, Year)*: 9/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. SCOTT EDEN, M.D. 1410 FOREST DR, SUITE 22, ANNAPOLIS, Md 21403

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: SEP 25 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Vice, Sr.

2. Date of Death Month Day Year: September 18 1997

3. Time of Death: 9:30AM

4a. Facility Name (If not institution, give street and number): 431 Manor Road

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 301-18-7837

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 9,1922

9. Birthplace (State or Foreign Country): pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 431 Manor Road

10f. Zip Code: 21012

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chief Petty Officer

16b. Kind of Business/Industry: United States Navy

17. Father's Name (First, Middle, Last): Martin Fair

18. Mother's Name (First, Middle, Maiden Surname): Mary Vice

19a. Informent's Name/Relationship (Type, Print): Evelyn Vice

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 431 Manor Road Arnold MD. 21012

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Hillcrest Cemetery

Date: 9-22-97

20c. Location - City or Town, State: Annapolis, MD.

21. Signature of Funeral Service Licensee: Charles S. Chilton

22. Name and Address of Feciliity: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications that caused the death. Do nol enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. Brain Tumor — months

Due to (or es e consequence of):

Sequentieily list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest

b.

Due to (or as e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [X] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings aveilable prior lo completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one)

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [✓] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office buiiding, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as steted. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) end manner steted.

29b. Signature and title of certifier: James G. Chaconas

29c. License number: D16964

29d. Date signed (Month, Day, Year): September 18, 1997

30. Neme end eddress of parson who completed cause of deeth (Item 23a) (Type, Print): James G. Chaconas, M.D. 1509 Ritchie Hwy. Arnold, Maryland 21012 (410-757-7600)

State Registrar

31. Dete filed (Month, Day, Year): SEP 24 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annie Marie Voelker
2. Date of Death Month Day Year: September 19, 1997
3. Time of Death: 10:30 AM
4a. Facility Name (If not institution, give street and number): Mariner Health of North Arundel
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-03-5279
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 10, 1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6 Ivy Lane
10f. Zip Code: 21060
10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): -
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Painting

17. Father's Name (First, Middle, Last): Nils Sahlin
18. Mother's Name (First, Middle, Maiden Surname): Mary (Unknown)

19a. Informant's Name/Relationship (Type, Print): John Withington (Nephew)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3608 Chadwick Ct. Pasadena, Md. 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Western Cemetery
Date: 9/23/1997
20c. Location - City or Town, State: Baltimore City, Md

21. Signature of Funeral Service Licensee: Michael C. Zoffer
22. Name and Address of Facility: Singleton Funeral Home 1 Second Avenue S.W. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 5 years
Due to (or as a consequence of):
b. Arteriosclerotic cardiovascular disease — 5 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Elliott Gorbaty M.D.
29c. License number: D20094-MD
29d. Date signed (Month, Day, Year): 9/22/97
30. Name and address of person who completed cause of death (Item 29a) (Type, Print): ELLIOTT GORBATY, M.D., 7845 OAKWOOD ROAD, GLEN BURNIE, MARYLAND 21061

State Registrar

31. Date filed (Month, Day, Year): SEP 23 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

97-5526-033
UNK 97-215
ASP
MICHAEL ANTHONY WATERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Anthony Waters

2. Date of Death (Month, Day, Year): SEPTEMBER 27 1997

3. Time of Death: 7:57 P

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 219-72-5307

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 36 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 24, 1960

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Lothian

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5239 Sands Road

10f. Zip Code: 20711

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1978-1981

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician's Helper

16b. Kind of Business/Industry: Contractor

17. Father's Name (First, Middle, Last): Sherman Waters

18. Mother's Name (First, Middle, Maiden Surname): Barbara Thomas

19a. Informant's Name/Relationship (Type, Print): Barbara Hill/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5239 Sands Rd. Lothian, MD 20711

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Moses Cemetery

Date: 10/4/97

20c. Location - City or Town, State: Lothian, MD

21. Signature of Funeral Servica Licensee: ▶ Gladys A. Sewell

22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medicai Examiner

23a. Part1. Enter the disease, or complications thal caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. MULTIPLE INJURIES

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [✓] Yea 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Natural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dele of Injury (Month, Dey Year): 9 27 97

28b. Time of Injury: 1720 M

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: BICYCLIST STRUCK BY TRUCK

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify): ROSMURY

28f. Location (Street and Number or Rural Route Number, City or Town, State): RTE 301 PRINCE GEORGES CO MD

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end placa, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signature end title of certifier: ▶ Wayne Brettell MD

29c. License number: O.C.M.E

29d. Dete signed (Month, Day, Year): SEPTEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARYANN B. KOPROWSKI MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): OCT 02 1997

32. Registrar's Signature: ▶ Lisa Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

471

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31388

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilbert O. Weaver, Jr.

2. Date of Death Month Day Yaar: September 20, 1997

3. Time of Death: 3:05 PM

4a. Facility Name *(If not institution, giva street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-46-0942

6. Sex: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 50 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 23, 1947

9. Birthplaca *(Stata or Foreign Country)*: West Virginia

Usual Rasidance of Decedant

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Churchton

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 5502 Baskin Street

10f. Zip Coda: 20733

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Navar Marriad 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12th — Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT usa retired)*: Radio Dispatcher

16b. Kind of Business/Industry: Moving Company

17. Fathar's Nama *(First, Middla, Last)*: Wilbert O. Weaver

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Helen Louise Triantafillos

19a. Informant's Neme/Ralationship *(Type, Print)*: Linda A. Risden/ Sister

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 5502 Baskin Street Churchton, Maryland 20733

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, crematory or othar place)*: Metropolitan Crematory — Data: 9-21-97

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Wilbert Kalas

22. Nama and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death

Immediata Cause (Finel disaasa or condition rasulting in daath)
a. Squamous Cell Carcinoma R Thu lung — 1 yr

Due to (or as a consequence of):

Sequantially tist conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequanca of):
c.

Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yas 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa refarrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath *(Check only ona)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Other *(Specify)*

27. Mannar of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be datarminad

26a. Data of Injury *(Month, Day Yaar)*

26b. Time of Injury M

26c. Injury at Work? 1 [ ] Yas 2 [ ] No

26d. Describe how injury occurred

28a. Placa of Injury - At home, farm, street, fectory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and piace, and dua to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, date and place, and due to the cause(s) and mannar stated.

29b. Signatura and title of certifiar: Wayne Bierbaum MD

29c. Licansa number: D38563

29d. Data signed *(Month, Day, Year)*: September 21, 1997

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Wayne O. Bierbaum 134 Owensville Rd West River MD 20778

State Registrar

31. Data filed *(Month, Day, Year)*: SEP 23 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31389

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herman Robert Welch

2. Data of Daath: Month SEPTEMBER Day 27 Yaar 1997

3. Tima of Death: 6:25AM

4a. Facility Nama (If not institution, giva street and number): JOHNS HOPKINS BAYVIEW

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Numbar: 235-28-1436

8. Sax: 1☒M 2☐F

7. Aga (In yrs. last birthday): 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): April 15, 1920

9. Birthplaca (State or Foraign Country): Virginia

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Darlington

10d. Insida City Limits: 1☐Yas 2☒No

10e. Street and Number: 3332 Hughes Road

10f. Zip Code: 21034

10g. Citizen of What Country: USA

11. Marital Status: 1☐Navar Marriad 2☒Marriad 3☐Widowad 4☐Divorcad

12. Was Decedent Evar in U.S. Armed Forcas? 1☒Yas 2☐No If Yas, Giva Yaar or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Decedent's Educetion (Specify only highast grada compliated): Elamentary/Secondary (0-12): 8; Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): Coal Miner

16b. Kind of Businass/Industry: Strip Mining

17. Fathar's Nama (First, Middla, Last): Clyde Oscar Welch

18. Mothar's Nama (First, Middla, Maidan Surnama): Anna Mabel King

19a. Informant's Nama/Ralationship (Type, Print): Nellie M. Welch, Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 3332 Hughes Road, Darlington, Maryland 21034

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Placa of Disposition (Nama of cematary, crematory or othar placa): Bel Air Memorial Gardens

Data: 9/30/97

20c. Location - City or Town, Stata: Bel Air, Maryland

21. Signature of Funaral Sarvica Licansee: Stephen A. Waugh

22. Nama and Addrass of Facility: Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that ceusad tha deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

		Approximata Interval Between Onset and Death
Immediate Ceuse (Final disaasa or condition resulting in daeth) a.	SEPSIS	1 week
Dua to (or as e consequence of): b.	PNEUMONIA	1 week
Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last — Dua to (or as a consequance of): c.	URINARY TRACT INFECTION	2 weeks
Dua to (or as a consequanca of): d.		

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying ceusa givan in Part I.

PNEUMOCONIOSIS

CLOSTRIDIUM DIFFICILE

23b. Did tobacco use contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐Yas 2☒No

25. Was casa rafarrad to medical examiner? 1☐Yas 2☒No

26. Placa of Death (Check only ona): Hospital: 1☒Inpatiant 2☐ER/Outpatiant 3☐DOA Other: 4☐Nursing Homa 5☐Rasidance 8☐Othar (Specify)

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be datarmined

26a. Data of Injury (Month, Day Yaar)

26b. Tima of Injury

26c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒Certifying Physician: To tha best of my knowledga, deeth occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and titla of certifier: Victoria Porter MD

29c. Licansa number: 97023

29d. Data signed (Month, Day, Yaar): September 27, 1997

30. Nama and addrass of parson who compliated causa of daath (Item 23a) (Type, Print): VICTORIA PORTER 4940 EASTERN AVE BALTIMORE, MARYLAND 21240

State Registrar

31. Data filad (Month, Day, Yaar): SEP 29 1997

32. Registrar's Signatura: Judi Anderson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10 of 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31390

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: MARY JEAN WELSH
2. Data of Death Month Day Year: OCTOBER 1, 1997
3. Tima of Deeth: 1558
4a. Facility Nama *(If not institution, giva street and number)*: ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 220-24-5844
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 12-8-28
9. Birthplaca *(Stata or Foraign Country)*: MD

Usual Rasidanca of Dacedant

10a. Stata: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN CITY
10d. Insida City Limits: 1☐ Yas 2☒ No
10e. Street and Numbar: 12415 KENT RTD.
10f. Zip Coda: 21842
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Raca - American Indian, Black, White, atc. *Specify:* WHITE

15. Decadant's Education *(Spacify only highast grada complatad)*: Elamantary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: HOMEMAKER
16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Name *(First, Middle, Last)*: JOHN M. MILEEW, SR.
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: BERNADINE HEYING

19a. Informant's Name/Relationship *(Type, Print)*: JEROME E. WELSH, SR.
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: KENT RD., OCEAN CITY, MD., 21842

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: SALISBURY CREMATORY
Data: 10-2
20c. Location - City or Town, Steta: SALISBURY, MD.

21. Signature of Funeral Service Licensee: John A Mileeu
22. Nama and Addrass of Facility: ULLRICH FUNERAL HOME BERLIN, MD.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onsat and Daath

Immediate Ceuse (Finet disaasa or condition resulting in deeth)
a. Congestive Heart Failure — years
Due to (or as e consequanca of):
b. Atrial Fibrillation — years

Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Ceuse (Diseese or Injury that initieted avants rasulting in daath) Last
c.
Due to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performad? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was casa referred to medical examinar? 1☐ Yas 2☒ No
26. Place of Deeth *(Check only ona)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residanca 6☐ Othar *(Specify)*
27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not ba datarmined
28e. Data of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Steta)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and place, and dua to tha cause(s) and mannar as steted. 2☐ **Madical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.
29b. Signature and tita of cartifiar: Benjamin H Meyer
29c. License number: D30743
29d. Data signed *(Month, Day, Yaar)*: 10/2/97
30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Benjamin Meyer. PO Box 49, Salisbury, md 21803

State Registrar

31. Data filed *(Month, Day, Yaar)*: OCT 03 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

9

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DEREK THOMAS WHITNEY
2. Date of Death Month Day Year: SEP 22 1997
3. Time of Death: 1:08 PM
4a. Facility Name (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: Not Available
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months: Days: 2; If Under 24 Hrs. Hours: Min.:
8. Date of Birth (Month, Day, Year): 09 20 1997
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Vienna
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 8213 Cottage Street
10f. Zip Code: 22180
10g. Citizen of What Country?: USA

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Not Available
16b. Kind of Business/Industry: Not Available

17. Father's Name (First, Middle, Last): Jason Whitney
18. Mother's Name (First, Middle, Maiden Surname): Kellie Galvin

19a. Informant's Name/Relationship (Type, Print): Jim Galvin (Grandfather)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8213 Cottage Street Vienna, Virginia 22180

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fairfax Memorial Park
Date: Sept 25
20c. Location - City or Town, State: Fairfax Virginia

21. Signature of Funeral Service Licensee
22. Name and Address of Facility: Affordable Funeral Services 2230 Gallows Road, Dunn Loring VA 22027

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. EXTREME PREMATURITY
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Russell R Moores Jr MD
29c. License number: D-41551
29d. Date signed (Month, Day, Year): 09/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): R. MOORES, JR., LTC, MC USA
NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year): OCT 18 1997
32. Registrar's Signature: Julia Davidson-Gonzales

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31392

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Louise Wilson
2. Date of Death Month Day Year: September 29, 1997
3. Time of Death: 6:28 PM
4a. Facility Name *(If not institution, give street and number)*: 1986 Chipper Road
4b. City, Town, or Location of Death: Edgewood
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 212-28-3132
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-22-1931
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1986 Chipper Road
10f. Zip Code: 21040
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress
16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Charles Frederick Wagner
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Lee Grover

19a. Informant's Name/Relationship *(Type, Print)*: Daughter Mrs. Barbara Donahoe
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1986 Chipper Road, Edgewood, MD 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gdns.
Date: 10/3/97
20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: William S. Smith
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. chronic renal Failure — 2years

Due to (or es a consequence of):
b. Type 2 Diabetes Mellitus — 10years

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other eignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.
hepatic dysfunction
peripheral vascular disease
coronary artery disease

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☑ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings evellable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: J. M. Nichols MD
29c. License number: D29197
29d. Date signed *(Month, Day, Year)*: 9/30/97

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): J. M. NICHOLS MD 9101 FRANKLIN SQUARE DR - 205 BALTO, MD 21237

State Registrar

31. Dete filed *(Month, Dey, Year)*: SEP 30 1997
32. Registrar's Signeture: Judith Hinderson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES WILLIAMS
2. Date of Death: Month Sept Day 05 Year 97
3. Time of Death: 5:45 PM
4a. Facility Name (If not institution, give street and number): University of MARYLAND MEDICAL
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 219-26-8823
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 1-28-39
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 308 Elizabeth Ave.
10f. Zip Code: 21225
10g. Citizen of What Country? USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Ukn; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Bay Ridge Inn

17. Father's Name (First, Middle, Last): Ukn
18. Mother's Name (First, Middle, Maiden Surname): Ukn

19a. Informant's Name/Reletionship (Type, Print): Jackie Berger (Social Worker
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 80 West Street Annapolis, Md. 21401

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Woschell Cemetery
Date: 9/16/97
20c. Location - City or Town, State: Balto.

21. Signature of Funeral Service Licensee: Jeff Miller
22. Name and Address of Facility: Jeff Miller F/H 1639 N. Broadway Balto. Md.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death):
a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:
b. SQuamous cell cancer of Tongue

Due to (or as a consequence of):
c. Renal Failure

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attan Kasid House Staff
29c. License number: AU 4176 435 8729
29d. Date signed (Month, Day, Year): 9/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ATTAN KASID, M-D, Medicine Department, UMMS, Baltimore

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): SEP 19 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31394

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILTON WILLIAMS
2. Date of Death: Month 09 Day 27 Year 97
3. Time of Death: 1525
4a. Facility Name (If not institution, give street and number): ALICE B. TAWES NURSING HOME
4b. City, Town, or Location of Death: CRISFIELD
4c. County of Death: SOMERSET

Funeral Director

5. Social Security Number: 218-14-4333
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03-10-17
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Somerset
10c. City, Town or Location: Crisfield
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 109 Somers Cove Apt.
10f. Zip Code: 21817
10g. Citizen of What Country?: U.S

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade compieted): Elementery/Secondary (0-12): 10th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Somerset County

17. Father's Name (First, Middle, Last): George Williams
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Williams

19a. Informant's Name/Relationship (Type, Print): Bernice Taylor / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Somers Cove Apt. Crisfield, MD 21817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ebenezer Cemetery | Date: 10/2/97
20c. Location - City or Town, State: Marumsco, MD

21. Signature of Funeral Service Licensee: Anthony E. Waid
22. Name and Address of Facility: Anthony E. Waid Funeral Home 30639 Hampden Ave Princess Anne MD 21853

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMA OF THE TONGUE — May 97 — 5 MO.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

INSULIN DEPENDENT DIABETIS MELITUS
SPASTIC HEMIPLEGIA
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examinar**: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Vasantha. Pai. P
29c. License number - D0051736
29d. Date signed (Month, Day, Year): 09-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): SEP 30 1997
32. Registrar's Signature: Gaba Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #s 19b, 20c; 10/2/97 NBS, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31395

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLENN A. WILLIG, JR
2. Date of Death (Month, Day, Year): September 30, 1997
3. Time of Death: 7:10 am
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-32-0701
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 1, 1933
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: maryland
10b. County: Allegany
10c. City, Town or Location: Oldtown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 17205 Big Pond Place
10f. Zip Code: 21555
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1953-54
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/ Operator
16b. Kind of Business/Industry: Auto Body Shop

17. Father's Name (First, Middle, Last): Glenn A. Willig, Sr
18. Mother's Name (First, Middle, Meiden Surname): Pearl E. (Kitzmiller)

19a. Informant's Name/Relationship (Type, Print): Michelle J. Lochner
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT # 1 Box 469C, Imler, Pennsylvania 16655

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Davis Memorial Cemetery — Date: 10/2/97
20c. Location - City or Town, Stete: ~~Davis~~ Cumberland, MD

21. Signature of Funeral Service Licensee: Willard Kight
22. Name end Address of Facility: Kight Funeral Home, 309-311 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): e. REFRACTORY ACUTE MYELOID LEUKEMIA — April 1997

Due to (or as e consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given In Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Piece of Death (Check only one): Hospitel: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [✓] Naturei 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner as stated. 2 [ ] Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D 23371
29d. Date signed (Month, Dey, Year): SEPT 30, 97

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Qamar Zaman-Johnson Heights Medical Building-Cumberland, MD 21502

State Registrar

31. Dete filed (Month, Dey, Year): OCT 02 1997
32. Registrer's Signeture: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

3 NBS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31396

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lonnie Edward Wiseman

2. Date of Death Month / Day / Year: Sept 26, 1997

3. Time of Death: 1:30 P.M.

4a. Facility Name *(If not Institution, give street and number)*: Garrett Co. Memorial Hospital

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 213-26-2974

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 24, 1929

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Garrett

10c. City, Town or Location: Oakland

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 344 Dennett Road

10f. Zip Code: 21550

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 th / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembler

16b. Kind of Business/Industry: Automotive

17. Father's Name *(First, Middle, Last)*: Boyd Wiseman

18. Mother's Name *(First, Middle, Maiden Surname)*: Ada Pyle

19a. Informant's Name/Relationship *(Type, Print)*: wife Rosalind J. Eggleston-Wiseman

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 344 Dennett Rd., Oakland, MD 21550

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Country Side Crematory, Data: Sept 27,97

20c. Location - City or Town, State: Davidsville, PA

21. Signature of Funeral Service Licensee: D Lee Newman

22. Name and Address of Facility: Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — 2 Mon.

Due to (or as a consequence of):

b. Tachyarrythmia — 2 Yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Squamous Cell CA right Lung, COPD, Non Insulin dependent Diabetes Mellitus, Myocardial Infarction

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Margaret A. Kaiser

29c. License number: D26650

29d. Date signed *(Month, Day, Year)*: Sept 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Margaret A. Kaiser, M.D. PO Box 486 Oakland, MD 21550

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

20 MS

97-5254-510
CIP
CARL WALFORD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31397

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Karl Ashby Woolford
2. Date of Death (Month, Day, Year): SEPTEMBER 13, 1997
3. Time of Death: 10:40AM
4a. Facility Name (If not institution, give street and number): HOPKINS BAYVIEW HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: Unknown
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 35 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 4, 1962
9. Birthplace (State or Foreign Country): Alexandria Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore (City)
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2413 Foster Avenue
10f. Zip Code: 21224
10g. Citizen of What Country? United States of America

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Automotive Repair
17. Father's Name (First, Middle, Last): David Ashby Woolford
18. Mother's Neme (First, Middle, Maiden Surneme): Shirley Blevins
19a. tnformant's Neme/Relationship (Type, Print): Shirley B. Moon /Mother
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6109 Jefferson Mill Road, Scottsville, VA 24590
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Riverview Cemetery
Dete: 9/18
20c. Location - City or Town, State: Charlottesville, Virginia
21. Signature of Funeral Service Licensee: #M00690 Howard A Carson
22. Name and Address of Facility: Hill and Wood Funeral Home 201 1st Street, North, Charlottesville, VA 22902

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart faiture. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Contact Gunshot wound of the head
Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Cause (Diseese or injury thet Initieted events resulting in death) Last
b.
Due to (or as e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other signifIcent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? Limited 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings aveiiable prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Wes case referred to medical examiner? XX Yes 2 [ ] No

26. Piace of Deeth (Check only one): Hospitel: 1 [XX] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 9-12-97
28b. Time of Injury: 1958 M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Self inflicted gunshot wound
28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify): Home
28f. Location (Street end Number or Rural Route Number, City or Town, Stete): 2413 Foster Avenue Baltimore City, Maryland

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner es steted. XX **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: Stephen S. Radentz, MD
29c. License number: O.C.M.E.
29d. Date signed (Month, Dey, Yeer): SEPTEMBER 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Yeer): SEP 22 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31398

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY FRANCES WOODWARD
2. Date of Death (Month, Day, Year): September 27, 1997
3. Time of Death: 3:15 pm
4a. Facility Name (If not institution, give street and number): HARBOR Hospital Center
4b. City, Town, or Location of Death: BALTIMORE 21225 Balt. Mde
4c. County of Death:

Funeral Director

5. Social Security Number: 219-01-2102
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 31, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Edgewood
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1913 Harbinger Trail
10f. Zip Code: 21040
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decadent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Micholas William Czincila
18. Mother's Name (First, Middle, Maiden Sumeme): Mary Frances O'Neil
19a. Informent's Name/Relationship (Type, Print): Patricia Wakefield, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1913 Harbinger Trail, Edgewood, Maryland 21040
20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cametery, cremetory or other piece): Cedar Hill Cemetery
Dete: 9/30/97
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: ▶ Howard K. McComas
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)
a. Adult Respiratory distress Syndrome — 48 hrs
Due to (or es a consequence of):
b. CARCINOMA of Lung — unknown
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last
Due to (or as a consequence of):
c. Chronic obstructive pulmonary disease — unknown
Due to (or as a consequence of):
d. Atherosclerotic vascular disease — unknown

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Right Middle and lower lobe lobectomy with Lymph node dissection 9/24/1997

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: ▶ Kwang N. Kim MD
29c. License number: D17031
29d. Date signed (Month, Day, Year): Sep 27. 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KWANG N. Kim, MD 3001. S. HANOVER ST. BALTIMORE. MD 21225

State Registrar

31. Date filed (Month, Day, Year): 29 1997
32. Registrar's Signature: ▶

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31399

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julius A. Zemke

2. Date of Death Month Day Year: September 30, 1997

3. Time of Death: 1645

4a. Facility Name *(If not institution, give street and number)*: Laurelwood Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 166-01-7024

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 29, 1907

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 116 Montague Lane

10f. Zip Code: 21921

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Designer Engineer/ Owner

16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Karl Zemke

18. Mother's Name *(First, Middle, Maiden Surname)*: Unknown

19a. Informant's Name/Relationship *(Type, Print)*: Debbie Peterson - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 116 Montague Lane - Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Colestown Cemetery — Date: 10-4 1997

20c. Location - City or Town, State: Cherry Hill, New Jersey

21. Signature of Funeral Service Licensee: Daniel S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 West Stockton Street - Elkton, MD 21921-5521

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

E.T.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Lower G I bleed

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Rectal Cancer

Due to (or as a consequence of):

c. Cardio pulmonary arrest

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Type of certifier: X MR Ross MD

29c. License number: D43135

29d. Date signed *(Month, Day, Year)*: October 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): X Michael R. Ross 223 W. Main ST Elkton, MD. 21921

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 01 1997

32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / ~~Department~~ of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31400

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ISABEL STEWART ZUCCHELLI

2. Date of Death (Month, Day, Year): Sept 29 1997

3. Time of Death: 12:29 PM

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 067-03-6528

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 9, 1912

9. Birthplace *(State or Foreign Country)*: Canada

Usual Residence of Decedent

10e. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 706 Oak Road

10f. Zip Code: 21085

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Stenographer

16b. Kind of Business/Industry: City Government

17. Father's Name *(First, Middle, Last)*: William (nmn) Stewart

18. Mother's Name *(First, Middle, Maiden Surname)*: Elspet (nmn) Burnet

19e. Informent's Name/Relationship *(Type, Print)*: Emile Zucchelli - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 706 Oak Road, Joppa, Maryland 21085

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens

Date: 10-2-97

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Ceuse (Final disease or condition resulting in death)

e. Cerebrovascular disease — 3 years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

coronary atherosclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician**: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner**: On the basis of exemination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D2833

29d. Date signed *(Month, Day, Year)*: September 29, 1997

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): UNOA Rue Med 101 [illegible] Wheel Lord Bellen MD 21015

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 1 1997

32. Registrar Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Zucchelli

Isabell

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31401

Item: 12,per F.H. G-753 11/4/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry Lee Arthur, Sr.

2. Date of Death Month Day Year: October 15, 97

3. Time of Death: 9:20am

4a. Facility Name (If not institution, give street and number): 1547 Stonewood Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 216-34-3247

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 08-27-38

9. Birthplace (State or Foreign Country): SC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1547 Stonewood Road

10f. Zip Code: 21239

10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Amarican Indian, Black, Whita, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)

Elementary/Secondery (0-12): 12th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Steelworker

16b. Kind of Business/Industry: Bethlehem Steel Co.

17. Father's Name (First, Middle, Last): Hezekiah Alexander Arthur

18. Mother's Name (First, Middle, Maiden Surneme): Ella Williams

19a. Informant's Name/Relationship (Type, Print): Myrtle B. Arthur

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 21239: 1547 Stonewood Road Baltimore, Maryland

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☒ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Arbutus Mem. Pk. Cem.

Date: 10-18-97

20c. Location - City or Town, State: Arbutus, Md.

21. Signature of Funeral Service Licensee: Francis X. Kelly

22. Nama and Address of Facility: Baltimore, Maryland 21202 ~~WM~~ C.March FH 1101 E. North Avenue

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 17 months

Due to (or as a consequence of):

Sequentially list conditions, If any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in tha underlying ceuse given in Part I.

23b. Did tobacco uae contributa to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☒ No

25. Was cese referred to medicel examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Seamus O'Reilly

29c. Licansa number: D46515

29d. Date signed (Month, Dey, Year): October 16th 1997

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): Seamus O'Reilly, Johns Hopkins Oncology Center. Baltimore MD

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 17 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31402

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES L. AUSTIN

2. Date of Death Month: October Day: 12 Year: 1997

3. Time of Death: 6:30 pm

4a. Facility Name (If not institution, give street and number): UMMS - TCU

4b. City, Town, or Location of Death: Baltimore, MD

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 223-28-8866

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUN. 7, 1924

9. Birthplace (State or Foreign Country): VIRGINIA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD. 10b. County: N/A 10c. City, Town or Location: BALTIMORE 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2547 W. LOMBARD ST. 10f. Zip Code: 21223 10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STAFF WORKER

16b. Kind of Business/Industry: CIVIL SERVICE

17. Father's Neme (First, Middle, Last): PURNELL BRAXTON

18. Mother's Name (First, Middle, Meiden Surneme): MARY BRAXTON

19a. Informent's Name/Relationship (Type, Print): LENA SAULS

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6132 SERRENA LANE SAN DIEGO CALIF. 92154

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): METRO Date: 10/15/97

20c. Location - City or Town, State: BALTIMORE MD.

21. Signature of Funaral Service Licensee: Gary N. March

22. Name and Address of Facility: GARY N. MARCH FUNERAL HOME P.A 570 FREDERICK PASS BALT. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC PROSTATE CANCER — 3 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consaquence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the ceuse of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyalcian:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examination end/or Investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: N. Ahsmo

29c. Licansa number: P10327

29d. Data signed (Month, Dey, Year): Oct 12, 1997

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): Vivian L. Ahsmo MD 29 S. Paca St. Baltimore MD 21201

State Registrar

31. Dete filed (Month, Dey, Year): OCT 17 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

1 of 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31403

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Flora Ethel Andrews

2. Date of Death (Month, Day, Year): October 15 1997

3. Time of Death: 1:35 am

4a. Facility Name (If not institution, give street and number): Pleasant Living Convalescent Center

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-38-6183

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 108 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 13 1888

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Shady Side

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6495 West Shady Side Road

10f. Zip Code: 20764

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Robert Franklin Nowell

18. Mother's Name (First, Middle, Maiden Surname): Matilda Kirchner Nowell

19a. Informant's Name/Relationship (Type, Print): Glorious Shenton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6495 West Shady Side Rd. Shady Side, Md 20764

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodfield Cemetery

Date: 10/18

20c. Location - City or Town, State: Galesville Md

21. Signature of Funeral Service Licensee: ▶ Thomas A Hardesty

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CHF — 1 Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Harvey J. Steinfeld MD

29c. License number: D05158

29d. Date signed (Month, Day, Year): OCTOBER 16, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): HARVEY J. STEINFELD, M.D. 6131 SHADYSIDE RD. SHADYSIDE, MD 20764

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31404

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cornelia H. Arnold
2. Date of Death (Month, Day, Year): October 15, 1997
3. Time of Death: 7 A.M.

4a. Facility Name (If not institution, give street and number): 14 East Overlea Avenue, Apartment 11
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 213-03-8674
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 18, 1906
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore County
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14 East Overlea Avenue, Apartment 11
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant Clerk
16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Frederick Daniel Arnold
18. Mother's Name (First, Middle, Maiden Surname): Sophie Haug

19a. Informant's Name/Relationship (Type, Print): Frederick Arnold/Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 421 Ziglar Road, Stewartstown, Pennsylvania 17363

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery | Date: 10/17/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction — Approximate Interval Between Onset and Death: hours
Due to (or as a consequence of):
b. Ischemic Heart Disease — years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: 008358
29d. Date signed (Month, Day, Year): 10/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GRACIA M. PATRICIO 8903 HARFORD ROAD BALTIMORE MD 21234

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31405

Charles Baumgardner
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES W. BAUMGARDNER, JR.
2. Date of Death: Month October Day 14, Year 1997
3. Time of Death: 10:41 P.M.
4a. Facility Name (If not institution, give street end number): BON SECOUR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-14-7083
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 17 1923
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 442 S. SMALLWOOD STREET
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MAINTENANCE WORKER
16b. Kind of Business/Industry: HOSPITAL

17. Father's Name (First, Middle, Last): CHARLES W. BAUMGARDNER, SR.
18. Mother's Name (First, Middle, Maiden Surname): KATHRYN HASTINGS

19a. Informant's Name/Relationship (Type, Print): EVELYN BAUMGARDNER, WIFE
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 442 S. SMALLWOOD ST., BALTIMORE, MD 21223

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): CHESAPEAKE CREMATORY
Date: 10-18
20c. Location - City or Town, State: BELTSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ Phillip Starks
22. Name and Address of Facility: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE., BALTIMORE, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis
Due to (or as a consequence of):
b. Adult Respiratory Distress Syndrome
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Replaced Aortic Valve
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic Cardiovascular Disease
Coronary Artery Disease.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D Parker
29c. License number: D34730
29d. Date signed (Month, Day, Year): 10/16/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DONOVAN PARKES, M.D. BON SECOURS HOSPITAL 2000 W. BALTIMORE ST. BALTIMORE, MD 21223

8x1

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

97-5919-001
jhm
THOMAS WILLIAM
BECKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31406

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): THOMAS WILLIAM BECKER, SR.

2. Deta of Daath — Month: OCTOBER Dey: 15, Yeer: 1997

3. Time of Deeth: 07:10 PM

4e. Feclity Neme (If not institution, giva street end number): UNION RESCUE MISSION

4b. City, Town, or Location of Deeth: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 106-30-8209

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): July 29, 1940

9. Birthplece (Steta or Foreign Country): N.Y.

Usual Residence of Decedent

10e. Stete: Md.

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 16 Cross Keys

10f. Zip Coda: 21210

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No — If Yes, Give Yaar or Datas: 5/59 - 12/62

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): UnKnown

16b. Kind of Business/Industry: UnKnown

17. Fether's Neme (First, Middle, Last): William Becker

18. Mother's Neme (First, Middle, Meiden Surneme): Marie UnKnown

19a. Informent's Neme/Relationship (Type, Print): Mrs. Diane Becker/wife

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 16 Cross Keys Baltimore, Md. 21210

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Garrison Forest Vetrans — Date: 10/20/97

20c. Location - City or Town, Stete: Owings Mills, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not entar tha mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onsat end Death

Immediate Ceuse (Final disease or condition resulting in death): e. Atherosclerotic Cardiovascular Disease

Due to (or es e consequence of):

Sequantially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? Limited 1 [X] Yes 2 [ ] No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Piece of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Day Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, streat, fectory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner as stated. 2 [X] **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: [signature], MD

29c. Licensa number: OCME

29d. Data signad (Month, Day, Yaar): OCTOBER 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31407

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HERMAN BITTNER

2. Data of Death Month: October Day: 15 Yaar: 1997

3. Tima of Death: 6:35 p.m.

4a. Facility Nama *(If not institution, giva street and number)*: Stella Maris Hospice

4b. City, Town, or Location of Death: Timonium

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 220-30-2890

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. lest birthday)*: 88 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 7-10-1909

9. Birthplaca *(Stete or Foreign Country)*: New York

Usual Rasidenca of Dacadant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 2627 Hillcrest Ave.

10f. Zip Coda: 21234

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedent Evar in U,S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Dacedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use ratired)*: Laboratory Manager

16b. Kind of Business/Industry: Johns Hopkins University

17. Fether's Nama *(First, Middle, Last)*: Herman Carl Bittner

18. Mothar's Name *(First, Middla, Maiden Surnama)*: Rosalie Scherr

19a. Informent's Name/Ralationship *(Type, Print)*: Mrs Anne B. Aschemeier (DTR)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 2509 Edgewood Ave., Baltimore, Maryland 21234

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cematary, cramatory or othar place)*: Hilltop Service Corp.

Data: 10-21-97

20c. Location - City or Town, Stata: Towson, Maryland 21204

21. Signature of Funaral Sarvice Licensee: ▶ Wallace S Brooks, Jr.

22. Name and Addrass of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Entar tha diseese, or complicetions thet caused the deeth. Do not entar the mode of dying, such as cardiac or respiretory errast, shock, or haart failura. List only one causa *on* aach line.

Approximate Intarval Between Onsat end Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. METASTATIC CA OF LUNG

Dua to (or as a consequenca of):

Sequantially list conditions, if eny, laading to immadieta causa. Entar Undarlying Causa (Diseesa or Injury thet initiated avants rasulting in daath) Last

b. PROSTATE CA

Dua to (or es e consequanca of):

c. LEUKemia

Due to (or as a consequance of):

d.

Part II. **Other significant conditione** contributing to daath but not resulting in the undarlying cause givan in Part I.

23b. Did tobacco **usa contribute to the causa of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to compiation of causa of daath? 1☐ Yas 2☒ No

25. Was case referrad to medical exeminar? 1☐ Yas 2☒ No

26. Piece of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Rasidance 6☒ Othar *(Specify)* Hospice

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not ba determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, ferm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)* 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurred et tha tima, data and piece, end dua to tha causa(s) and manner as statad. 2☐ **Madical Exominer:** On the basis of axamination and/or invastigation, in my opinion, death occurred et the tima, data and place, and due to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifier: ▶ [signature]

29c. Licensa number: 17504

29d. Dete signad *(Month, Day, Yaer)*: 10.16.97

30. Nama and addrass of parson who complated cause of daath (Item 23a) (Type, Print): DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Data filed *(Month, Day, Yaer)*: OCT 17 1997

32. Registrar's Signatura: ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31408

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Charles Baranowski
2. Data of Death Month Day Year: October 10, 1997
3. Time of Death: 6:50PM
4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM
4b. City, Town, or Location of Death: Perry Point
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 203-01-8476
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 75 Yrs. If Under 1 Yaar: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Yeer): Aug. 11 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Rasidence of Decedent

10a. Stata: Maeyland
10b. County: Haeford
10c. City, Town or Location: Bel Air
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 408 Chadford Ct.
10f. Zip Code: 21014
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12YRS; College (1-4or 5+): 2YRS
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life, DO NOT use retired): Lt. Colonel
16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middla, Last): Charles Baranowski
18. Mother's Name (First, Middle, Meiden Surneme): Pauline Novak

19a. Informant's Name/Relationship (Type, Print): Anne L. Baranowski
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 408 Chadford Ct. Bel Air Md 21014

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Neme of cematary, crematory or other piece): Garrison Forest Cemetery
Data: Oct 16 1997
20c. Location - City or Town, State: Garrison, Maryland
21. Signature of Funeral Service Licensee: Krista S. Wells
22. Name and Address of Facility: Evans Funeral Chapel-Bel Air 3 Newport Dr. Forest Hill, Md 21050

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complicatians that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediata Cause (Finai disease or condition resulting in death)
a. Brain Tumor — Approximate Interval: 15 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the cauae of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☐No

25. Was cese referred to medical examiner? 1☐Yes 2☒No
26. Place of Death (Check only one): Hospital: 1☒Inpetient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Manuel Ramos MD
29c. License number: D38950
29d. Date signed (Month, Day, Year): October 10, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): MANUEL RAMOS, M.D. VA MARYLAND HEALTH CARE SYSTEM, Perry Point, MD 21902

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Jacke Davidson-Randall

DHMH 16 Rev 6/95

1541

NAME KNOWN TO PHYSICIAN: BARANOWSKI, RAYMOND C.
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Public Reports Should Be Made Within 72 Hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME KNOWN TO PHYSICIAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31409

Item: 26 per Physician G-752 10/17/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): REGINA COELI BAILLARGEON

2. Date of Death: Month OCTOBER Day 15, Year 1997

3. Time of Death: 11:30AM

4a. Facility Name (If not institution, give street and number): 719 MAIDEN CHOICE LANE - BROOKSIDE -522

4b. City, Town, or Location of Death: CATONSVILLE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-32-2453

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APRIL 11,1935

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: CATONSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 719 MAIDEN CHOICE LANE - BR-522

10f. Zip Code: 21228

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 6 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: CATHOLIC SCHOOL

17. Father's Name (First, Middle, Last): EDWARD KERNAN

18. Mother's Name (First, Middle, Maiden Surname): EDNA MEHAN

19a. Informant's Name/Relationship (Type, Print): ROGER BAILLARGEON(HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 MAIDEN CHOICE LANE-BR-522-CATONSVILLE, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): NEW CATHEDERAL CEMETERY

Date: 10/18/97

20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — 2wks

Due to (or as a consequence of):

b. Diabetes Mellitus — 20yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequance of):

d. End Stage Renal Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Multiinfarct Dementia, Anemia

Severe Diabetic Gastroparesis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mary T. Behrens, MD Nephrologist

29c. License number: D38747

29d. Date signed (Month, Day, Year): 10/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. MARY T. BEHRENS - 716 MAIDEN CHOICE LANE - SUITE 302 - CATONSVILLE,MD 21228

REB

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

24

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31410

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Stella R. Butka
2. Data of Death Month Day Year: Oct. 14, 1997
3. Time of Death: 10:15pm
4a. Facility Name (If not Institution, give street and number): 6503 Kenwood Ave.
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-07-2240
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 5-4-10
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6503 Kenwood Ave.
10f. Zip Code: 21237
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress
16b. Kind of Business/Industry: Clothing Manufacturer

17. Father's Name (First, Middle, Last): Peter Frederick
18. Mother's Name (First, Middle, Maiden Surname): Mary Sasada

19a. Informent's Name/Relationship (Type, Print): John J. Butka Jr. / son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6503 Kenwood Ave. Rosedale, MD 21237

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory
Date: 10-15-97
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: ▶ Denis B. Kelly
22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death): e. Metastatic Breast Cancer — 7 Months

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings availeble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Veronica Deza, MD
29c. License number: D0051349
29d. Date signed (Month, Day, Year): 10/15/97

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print): Veronica Deza, M.D. 6327 Gray Sea Way, Columbia, MD 21045

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 17 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE E. BEEBY

2. Date of Death Month Day Year: OCTOBER 14, 1997

3. Time of Death: 5:30 AM

4a. Facility Name (If not institution, give street and number): STELLA MARIS

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217180600

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2-27-17

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 301 Patapsco Ave.

10f. Zip Code: 21237

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Social Security

17. Father's Name (First, Middle, Last): Francis J. Beeby

18. Mother's Name (First, Middle, Maiden Surname): Katherine M. Cutler

19a. Informant's Name/Relationship (Type, Print): Rita M. Beeby / sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 Patapsco Ave. Rosedale, MD 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith | Date: 10-16-97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ Denis S. Kelly

22. Name and Address of Facility: Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute myocardial infarction hours

Due to (or as a consequence of): Ischemic Heart Disease years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Reflux esophagitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D08358

29d. Date signed (Month, Day, Year): 10/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gracita V. PATRICIO 8903 HARFORD ROAD BALT-MD 21234

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31412

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Donald Bergamy, Senior
2. Dete of Deeth — Month: October Dey: 12, Yeer: 1997
3. Time of Deeth: 8:45 pm
4e. Fecility Neme (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Deeth: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-50-1704
6. Sex: X 1☐ M 2☐ F
7. Age (In yrs. last birthday): 51 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): 2-11-46
9. Birthpiece (State or Foreign Country): MD

Usuel Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Middle River
10d. Inside City Limits: 1☐ Yes X☐ No
10e. Street end Number: 8 Lycett Cr.
10f. Zip Code: 21220
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates: X
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Reca - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: N/A

17. Father's Neme (First, Middle, Last): unk. Bergamy
18. Mother's Neme (First, Middle, Meiden Surneme): Elizabeth unk.

19e. Informent's Name/Reletionship (Type, Print): Patricia Bergamy/wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8 Lycett Cr. Middle River, MD 21220

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Metro Crematory
Date: 10-16-97
20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funerel Service Licensee: Dennis L. Kelly
22. Neme end Address of Fecility: Cvach/Rosedale Funeral Home, 1211 Chesaco Ave. Rosedale, MD 21237

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet cause the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Cause (Finel diseese or condition resulting in death) e.	coagulopathy	3 weeks
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Lest b.	liver failure	3 weeks
Due to (or es e consequence of):		
c.	hypotension	3 weeks
Due to (or es e consequence of):		
d.	ruptured spleen	3 weeks

CERTIFICATE APPROVED BY MEDICAL EXAMINER

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

hepatitis B
hepatitis c
alcoholic cirrhosis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evellable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Plece of Deeth (Check only one): Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer): 9-19-97
28b. Time of Injury: 12:45 pM
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: fell at home, hit coffee table
28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 8 Lycett Circle, Middle River, MD

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated.

29b. Signature end title of certifier: Eric K. Nakamura surgical resident
29c. License number: M1356
29d. Date signed (Month, Dey, Yeer): October 14, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Eric K. Nakakura — Johns Hopkins Bayview Medical Center, 4940 Eastern Avenue, Baltimore, MD 21224

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Released on Approval by Medical Examiners Office

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Brannock Sr.
2. Date of Death Month Day Year: Oct. 10, 1997
3. Time of Death: 8:00 am
4a. Facility Name *(If not institution, give street and number)*: 2014 Summit Ave.
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 219382667
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 55 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: FEB 3, 1942
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2014 Summit Ave.
10f. Zip Code: 21237
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINE OPERATOR
16b. Kind of Business/Industry: BOX FACTORY

17. Father's Name *(First, Middle, Last)*: WILLIAM G. BRANNOCK
18. Mother's Name *(First, Middle, Maiden Surname)*: CLARA ANDREWS

19a. Informant's Name/Relationship *(Type, Print)*: DAVID J. BRANNOCK JR. / SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2014 SUMMIT AVENUE ROSEDALE, MD 21237

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METRO CREMATORY — Date: 10/13/97
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE 21237

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease (Cardiac Arrest) — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage renal Disease (Hodgkins pt)

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John E Anderson MD
29c. License number: D17272
29d. Date signed *(Month, Day, Year)*: 10-10-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John E Anderson MD 6830 Hospital Dr. Baltimore 21237

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Gina Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31414

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD N. CURTIS SR.

2. Date of Death: Month: October Day: 13 Year: 1997

3. Time of Death: 3:30 pm

4a. Facility Name *(If not institution, give street end number)*: Liberty Medical Center 2600 Liberty Heights BALTIMORE MD 21215

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-20-2515

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUN. 6 1912

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: XX Yes 2☐ No

10e. Street end Number: 1808 N. DUKELAND STREET

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Merried XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? XX Yes 2☐ No If Yes, Give Year or Detes: 43/46

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☐ XX No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12th; College (1-4or 5+): 3yrs

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Medical Technician

16b. Kind of Business/Industry: V.A. Medical Center

17. Fether's Neme *(First, Middle, Last)*: Nathaniel Sweets

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Ruth Sweets

19a. Informent's Name/Reletionship *(Type, Print)*: Inez F. Curtis/Wife

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1808 N. Dukeland St., Baltimore, Maryland 21216

20a. Method of Disposition: XX Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: BALTIMORE NATIONAL

Date: 10-17

20c. Location - City or Town, Stete: BALTIMORE, MARYLAND

21. Signeture of Funeral Service Licensee: Hani G. Close

22. Neme end Address of Fecility: WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediate Cause (Finel disease or condition resulting in deeth)

e. CARCINOMA of PROSTATE — unknown

Due to (or es a consequence of):

b. Dehydration. — 5days

Sequentielly list conditions, if eny, leading to immedlete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

peripheral vascular disease - unknown periods

IRON Deficiency Anemia. unknown periods

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Nature 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2☐ **Medcal Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, death occurred et the time, dete and plece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Kwang N. Kim MD

29c. License number: D17031

29d. Dete signed *(Month, Dey, Year)*: Oct. 13. 1997

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): KWANG N. KIM. MD Liberty Medical Center 2600 Liberty Heights BALTIMORE MD 21215

State Registrar

31. Date filed *(Month, Dey, Year)*: OCT 17 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31415

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Geneva Cook
2. Date of Death Month Day Year: October 2, 1997
3. Time of Death: 11:55 p.m.
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 250-30-2697
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 6, 1911
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 3705 W. Cold Spring Lane
10f. Zip Code: 21215
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No *Specify:*
14. Race - Americen indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Presser
16b. Kind of Business/Industry: Centennial Pressers

17. Father's Nama *(First, Middle, Last)*: Frank Burden
18. Mother's Name *(First, Middle, Malden Surname)*: Callie

19a. Informent's Neme/Relationship *(Type, Print)*: David Carroll / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3705 W. Coldspring Lane Baltimore, MD. 21215

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, cremetory or other place)*: Rosehill Cemetery
Date: 10/9
20c. Location - City or Town, State: Linden, New Jersey

21. Signature of Funeral Service Licensee: Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home 3572 Frederick Ave. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on aach line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disaase or condition resulting in death)
a. Bacterial Sepsis — 3 days

Due to (or as a consequence of):
b. Dehydration — 3 days

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury thet initieted events resulting in deeth) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part ii. **Other signiftcant conditions** contributing to death but not resulting in the underlying ceuse given in Part i.: Cerebral Vascular Disease

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabie prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Piace of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not ba determined

28a. Dete of tnjury *(Month, Day Year)*
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowiedge, death occurred et the time, dete and piace, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examinar:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: C.S. [illegible] M.D.
29c. Licensa number: AS-2402321-CH-93-47
29d. Date signed *(Month, Day, Year)*: October 3, 1997

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Charles M. Heaton M.D. Sinai Hospital, Baltimore, Maryland

State Registrar

31. Dete filed *(Month, Day, Yeer)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31416

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Theodore Colclough, Sr.

2. Date of Death Month Day Yeer: October 12, 97

3. Time of Deeth: 5:51pm

4a. Facility Name *(If not institution, give street end number)*: Mercy Stella Maris-Hospice

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 250-03-1663

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. lest birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 04-20-18

9. Birthplace *(Stete or Foreign Country)*: SC

Usual Residenca of Decedent

10a. State: Md.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2503 Frank Avenue

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes ☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11th Grade | College (1-4or 5+): NA

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: Federal Cleaners

17. Father's Name *(First, Middle, Last)*: Marion Colclough

18. Mother's Name *(First, Middle, Meiden Surneme)*: Janie B. Mack

19a. Informant's Name/Relationship *(Type, Print)*: Theodore Colclough, Jr.

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2503 Frank Avenue Baltimore, Maryland 21230

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Garrison Forest VA Cem. | Date: 10-17-97 | 20c. Location - City or Town, Stete: Owings Mills, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name end Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused this death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Deeth
Immediate Cause (Final disease or condition resulting in deeth) a.	PNEUMONIA	3 wks.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last b.	ASPIRATION	3 wks
Due to (or as a consequence of):		
c.	ALZHEIMER'S DEMENTIA	UNKNOWN
Due to (or as e consequence of):		
d.		

Pert II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings svailable prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of fnjury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physicisn**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete and place, end due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: ▶ F. Ferro MD

29c. License number: D40480

29d. Date signed *(Month, Dey, Year)*: October 13, 1997

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Fernando J. Ferro, MD | 7672 Beaver Rd Balto, MD 21236

State Registrar

31. Dete Filed *(Month, Dey, Year)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

THEODORE COLCLOUGH

(1)

5x1

97-5873-031
ML

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

EDWARD CUMMING Items: 23 part I, 27, 28a-f per MEO 11/6/97 reb

Certificate of Death

Reg. No. 97 31417

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD V. CUMMINGS

2. Date of Death — Month: OCTOBER Day: 14 Year: 1997

3. Time of Death: 7:05 AM

4e. Facility Name (If not institution, give street and number): 24711 OLD HUNDRED ROAD

4b. City, Town, or Location of Death: CLARKSBURG

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 221-60-9124

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 37 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): September 4, 1960

9. Birthplace (State or Foreign Country): Deleware

Usual Residence of Decedent

10a. State: Deleware

10b. County: New Castle

10c. City, Town or Location: Wilmington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 129 S. Gray Avenue

10f. Zip Code: 19805

10g. Citizen of Whet Country?: USA

11. Marital Status: ☒ 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: white

15. Decadent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12):

College (1-4or 5+): 5

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): adjustment research clerk

16b. Kind of Business/Industry: banking

17. Father's Neme (First, Middle, Last): John R. Cummings, Sr.

18. Mother's Name (First, Middle, Maiden Surneme): Mary T. Defanti

19a. Informent's Name/Reletionship (Type, Print): Ms. Mary T. Cummings/mother

19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 129 S. Gray Avenue, Wilmongton, DE 19805

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): entombment

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Cathedral Cemetery

Date: 18OCT97

20c. Location - City or Town, Stete: Wilmington, DE

21. Signature of Funeral Service Licensee: [signature] M00535

22. Name and Address of Facility: Krienan-Griffith, Inc. Wilmington, Deleware 19805

Physician /Medical Examiner

25. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in deeth)

a. HYPOGLYCEMIA COMPLICATING THERAPY FOR DIABETES MELLITUS

Due to (or es a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest

b.

Due to (or as e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? ☒ 1 Yes 2 ☐ No

26. Piece of Death (Check only one)

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☒ Other (Specify): SCENE

27. Manner of Deeth: 1 ☐ Neturel 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year): found 10/14/97

28b. Time of Injury: found at 6:30 A M

28c. Injury at Work? 1 ☐ Yes ☒ No

28d. Describe how injury occurred: Subject took too much insulin

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify): found in house

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): 24711 Old Hundred Road Comus, Maryland

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner es steted. ☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] Dennis J Chute M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Dey, Year): OCTOBER 14, 1997

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 17 1997

32. Registrar's Signature: [signature] Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Division of Vital Records, P.O. Box 68760,

15

97-5861-510
B.K.S

DARLENE DORSEY
Items:23a part I,27,28a-f per MEO G-752 10/27/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31418
Reg. No.

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): Darlene Dorsey
2. Date of Daath — Month: OCT. Day: 13, Yaar: 1997
3. Tima of Death: 11:51 AM
4a. Facility Nama (If not institution, giva straat and number): 2623 GREENMOUNT AVENUE
4b. City, Town, or Locatlon of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Numbar: 220-64-7471
6. Sax: 1☐ M 2☒ F
7. Aga (In yrs. last birthday): 43 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-14-54
9. Birthplaca (Stata or Foraign Country): Md

Usual Rasidanca of Dacadant

10a. Stata: Md
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Numbar: 2623 Greenmount Avenue
10f. Zip Coda: 21218
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yas, Give Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Dacedant's Education (Spacify only highast grada completed): Elamantary/Secondary (0-12): 10th Grade; Collega (1-4or 5+): NA
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Nursing Aide
16b. Kind of Business/Industry: Private Duty

17. Fathar's Nama (First, Middla, Last): John A. Stevenson
18. Mothar's Nama (First, Middla, Maidan Surname): Pearline Williams

19a. Informant's Name/Relationship (Typa, Print): Pearline Stevenson
19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Code): 21218 2623 Greenmount Avenue Baltimore, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)
20b. Place of Disposition (Nama of cametary, cramatory or othar placa): Baltimore Cemetery
Data: 10-18-97
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funaral Sarvica Licansaa: Francis X. Walsh WM
22. Nama and Addrass of Facility: F.C. March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part1. Enter the disaasa, or complications that causad the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on each line.

Approximata Intarval Between Onset and Daath

Immediate Ceuse (Final disaasa or condition rasulting in daath)
a. ACUTE NARCOTIC INTOXICATION
Due to (or as a consequence of):
b.
Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last
Dua to (or es a consequanca of):
c.
Dua to (or as a consaquance of):
d.

Part II. **Other signficant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☑ Yas 2☐ No
24b. Wera eutopsy findings availabla prior to completion of causa of death? 1☑ Yes 2☐ No

25. Was casa rafarrad to medical axaminar? ☒ Yes 2☐ No
26. Place of Daath (Chack only ona) — Hospital: 1☐ Inpatient 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Other (Specify)

27. Mannar of Daath: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☒ ~~Pending~~ Investigation 6☒ Could not ba datarminad
28a. Date of Injury (Month, Day Yaar): found 10/13/97
28b. Tima of injury: found:11:40 A M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: unknown
28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify): found at home
28f. Location (Straat and Number or Rural Route Number, City or Town, State): 2623 Greenmount Avenue, Baltimore, Maryland

29a. Cartifier (Check only one): 1☐ **Cartifying Physician**: To the bast of my knowladga, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☒ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar stated.
29b. Signature and title of cartifiar: Dennis J. Chuke MD
29c. Licansa number: O.C.M.E
29d. Data signed (Month, Day, Year): OCT. 14, 1997

30. Nama and address of parson who completed cause of daath (Item 23a) (Type, Print): Dennis J. Chuke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31419

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM R. DRYDEN

2. Date of Death Month: OCTOBER Day: 15 Year: 1997

3. Time of Death: 12:25 pm

4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS BAYVIEW

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 219-32-4167

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 2 1936

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1303 Ballard Way

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Maritel Status: 1☒ Nevar Merried 2☐ Merried 3☐ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attendant

16b. Kind of Business/Industry: Gas Station

17. Father's Name *(First, Middle, Last)*: Francis Dryden

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy E. Byer

19a. Informant's Name/Raletionship *(Type, Print)*: Diane Zlotkowski / sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 21034: 3305 Harmony Church Rd Darlington, Md

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: Metro Crematory

Date: 10-17-97

20c. Location - City or Town, State: Catonsville, Md

21. Signeture of Funerel Service Licensee: Anthony Colt Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heert feilure. List only one cause on eech line.

Approximete Intarval Between Onset and Death

Immadieta Cause (Finel disease or condition resulting in daath): a. PNEUMONIA — ONE DAY

Due to (or es e consequance of):

b. ASPIRATION — TWO WEEKS

Sequentielly list conditions, if eny, leading to immedieta causa. Enter Underlying Causa (Disaase or Injury thet initieted events resulting in daeth) Lest

Due to (or as a consequenca of):

c. CEREBROVASCULAR ACCIDENT — TWO WEEKS

Due to (or es e consequence of):

d. HYPERTENSION — TWENTY YEARS

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause givan in Part I.: DIABETES

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings avellebla prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes casa referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Mannar of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladga, daath occurred at the time, date and pleca, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and pleca, and due to the causa(s) and menner stated.

29b. Signature and title of certifier: PHYSICIAN

29c. Licansa number: 97024

29d. Date signed *(Month, Day, Yeer)*: OCTOBER 15 1997

30. Nema and address of person who completed cause of daeth (Item 23e) (Type, Print): CARLOS PORTERA-CAILLIAU, JOHNS HOPKINS BAYVIEN HOSPITAL

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31420

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Virginia Dorbert

2. Date of Death Month / Day / Year: October 14 1997

3. Time of Death: 9:30 pm

4e. Facility Name *(If not institution, give street and number)*: 1540 Rosewick Avenue

4b. City, Town, or Location of Death:

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-28-7831

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: 8-8-1931

9. Birthplece *(Steta or Foreign Country)*: Baltimore,MD

Usuel Residence of Decedent

10e. Steta: MD

10b. County: Baltimore

10c. City, Town or Location: Rosedale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Streat end Number: 1540 Rosewick Avenue

10f. Zip Code: 21237

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Wes Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grede completed)*: Elementery/Secondery (0-12): 11th | College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Businass/Industry: In own home

17. Fether's Nema *(First, Middle, Last)*: John Sprezian

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Irene Brightwell

19e. Intormant's Name/Relationship *(Type, Print)*: John McDonough

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 12 Horney Court, Baltimore, Maryland 21221

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Gardens of Faith

Dete: 10/18/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Servica Licensee: ▶ Maria M Zannino

22. Nama and Address of Facility: Joseph N. Zannino Jr. Funeral Hm. 263 S. Conkling St. Baltimore, Maryland 21224

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complicetions thet caused tha daath. Do not enter the moda of dying, such es cardiac or respiretory errest, shock, or haart teilure. List only ona causa on each line.

Approximete Intervel Between Onsat and Deeth

Immedlete Ceuse (Finel disease or condition resulting in death)

e. Beta Static FEMT Tumor — 4 years

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest

b.

Due to (or es e consequence ot):

c.

Due to (or es e consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy tindings availebla prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was case refarred to medical examiner? 1☒ Yes 2☐ No

26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner ot Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, term, street, tectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis ot exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ M. Purtell Staff Physician

29c. Licensa number: D19714

29d. Data signed *(Month, Dey, Year)*: 10/16/97

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Michael Purtell, JHBMC 4940 Eastern Ave, Baltimore, Md 21224

State Registrar

31. Dete tiled *(Month, Day, Yeer)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31421

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANTHONY L DIGENNARI
2. Date of Death Month Dey Yaar: OCTOBER 14, 1997
3. Time of Death: 9:03 AM
4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 186-62-6589
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 28 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG 25, 1969
9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Rasidanca of Decedent

10a. Stata: PA.
10b. County: LUZERNE
10c. City, Town or Location: Nuangola
10d. Insida City Limits: 1 [ ] Yas 2 [X] No
10e. Street end Number: 5094 Nuangola Rd.
10f. Zip Coda: 18707
10g. Citizan of What Country?: USA

11. Maritel Status: 1 [X] Navar Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorcad
12. Was Decadant Ever in U.S. Armad Forces? 1 [ ] Yas 2 [X] No If Yas, Give Year or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Amarican Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Spacify only highest grada compiatad)*: Elamentary/Sacondary (0-12): 12 | Collaga (1-4or 5+): 2
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Computer SPECIALIST
16b. Kind of Businass/Industry: Transportation

17. Fether's Nama *(First, Middla, Lest)*: Dominick J. DiGennari
18. Mothar's Name *(First, Middla, Maidan Sumama)*: Patricia A. KAZOKAS

19a. Informant's Name/Raletionship *(Type, Print)*: Dominick J. DiGennari/father
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5094 Nuangola Rd. Nuangola PA 18707

20a. Mathod of Disposition: 1 [X] Buriel 2 [ ] Cramation 3 [ ] Ramoval from State 4 [ ] Donation 5 [ ] Othar *(Spacify)*
20b. Place of Disposition *(Name of cametary, cramatory or othar place)*: St. Mary's Ann. Cem | Data: OCT 17 1997
20c. Location - City or Town, Stata: Pringle, PA

21. Signatura of Funaral Service Licensee: [signature]
22. Nama and Addrass of Facility: Evans Chapel of Memories 8600 Harford Rd Balto Md

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona causa on each line.

Approximate Intarval Batwaan Onsat and Death

Immadiata Cause (Final diseasa or condition resulting in daath)
a. SEPTIC SHOCK — 24 HOURS

Due to (or as a consequance of):
b. GRAFT VERSUS HOST DISEASE — 4 MONTHS

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or Injury that initieted events resulting in daath) Last

Dua to (or as a consaquance of):
c. BEREBRAL SEPTIC EMBOLI — 24-48 HOURS

Dua to (or as a consequance of):
d. ACUTE LYMPHOBLASTIC LEUKEMIA — 10 MONTHS

Part II. **Othar significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobecco use contribute to the cause of death?** 1 [ ] **Yes** 2 [X] **No** 3 [ ] **Probably** 4 [ ] **Unknown**

24a. Was an autopsy parformed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings eveilabla prior to completion of causa of daath? 1 [ ] Yas 2 [ ] No

25. Was case referrad to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath *(Check only one)*: Hospitel: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [ ] Rasidanca 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Investigation 6 [ ] Could not be datarminad

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*
28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledge, daath occurred at the time, dete end placa, and dua to tha causa(s) and manner as steted. 2 [ ] **Medical Examiner:** On tha basis of axamination end/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: [signature]
29c. License number: D47953
29d. Data signed *(Month, Day, Year)*: 10/14/97

30. Nama and address of person who complatad cause of death (Item 23a) (Type, Print): JOHNS HOPKINS HOSPITAL, ONCOLOGY CENTER, BALTIMORE, MD

State Registrar

31. Data filed *(Month, Dey, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31422

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: EMMITT A. DEAN, JR.

2. Dete of Deeth — Month: AUGUST Dey: 24, Year: 1997

3. Time of Death: 1:29 pm

4a. Facility Nama *(If not institution, giva street and number)*: WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-72-9533

6. Sax: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 40 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: Oct. 18, 1956

9. Birthplece *(Stete or Foreign Country)*: Washington, Dc

Usuel Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7401 New Hampshire Ave., #410

10f. Zip Code: 20783

10g. Citizan of Whet Country?: U.S.A.

11. Maritai Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yas, specify Cuben, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elamentery/Secondery (0-12): 12th — College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dishwasher

16b. Kind of Business/Industry: Old Ebbitt Grill

17. Fether's Neme *(First, Middle, Last)*: Emmitt A. Dean, Sr.

18. Mother's Neme *(First, Middle, Melden Surneme)*: Madelyne Young

19a. Informant's Neme/Reletionship *(Type, Print)*: Madelyne Dean - Mother

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7401 New Hampshire Ave., #410, Hyattsville, MD 20783

20a. Mathod ot Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place ot Disposition *(Name of cemetery, cremetory or other piece)*: Harmony Memorial Park

Dete: 9-3-97

20c. Location - City or Town, Stete: Landover, Md.

21. Signeture of Funaral Service Licensee: J. P. Marshall

22. Nama and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximeta Interval Between Onset and Death

Immediete Ceuse (Finel disaesa or condition resulting in death)

a. Right Ventricular Dysplasia

Due to (or es e consequence ot):

Sequentially list conditions, it eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Lest

b.

Due to (or es e consequence ot):

c.

Due to (or es e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☒ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete ot Injury *(Month, Dey Year)*

28b. Time ot Injury M

28c. tnjury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of tnjury - At home, tarm, street, factory, office building, etc. *(Specify)*

28t. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Phyatcten:** To the best ot my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner as steted. 2☒ **Medtcal Examiner:** On the basis ot examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Stephen S. Paden, MD

29c. License number: OCME

29d. Data signed *(Month, Dey, Yeer)*: October 17, 1997 Re-issued

30. Name end address ot person who completed cause ot death (Item 23e) (Type, Print): Stephen S. Paden, MD Asst. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William George DOULONG
2. Date of Death Month Dey Year: October 13, 1997
3. Time of Death: 8:10 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-03-1996
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Dey, Year): 12-8-22
9. Birthplece (Steta or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stela: MD
10b. County: Baltimore
10c. City, Town or Location: Rosedale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8309 Berkfield Rd.
10f. Zip Code: 21237
10g. Citizen of Whet Country?: USA
11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highast grede completed) — Elementery/Secondary (0-12): Unk. — College (1-4or 5+): 0
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired): Machinist
16b. Kind of Business/Industry: Westinghouse
17. Fether's Neme (First, Middle, Last): George Doulong
18. Mother's Neme (First, Middle, Meiden Sumame): Bertha Waldman
19a. Informent's Neme/Reletionship (Type, Print): Elaine Doulong / sister
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8309 Berkfield Rd. Rosedale, MD 21237
20a. Mathod of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Remevel from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetary, cremetory or other piece): Bohemian National
Date: 10-17-97
20c. Location - City or Town, Stete: Baltimore, MD
21. Signature of Funeral Service Licensea: Denis S Kelly
22. Neme end Address of Fecility: Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter tha mode of dying, such es cerdiac or raspiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition resulting in death) a.	Pulmonary edema	one week
Due to (or es a consequence of): b.	Coronary artery disease	7 years
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseesa or Injury thet initieted events resulting in deeth) Lest — Due to (or es e consequance of): c.	Diabetes mellitus	10 years
Due to (or es e consequance of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the causs of death? 1 [ ] Yss 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examinar? 1 [ ] Yes 2 [X] No

28. Piece of Death (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Hema 5 [ ] Rasidance 8 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On tha besis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Mary Craig MD.
29c. Licensa number: R D 2097
29d. Dete signed (Month, Day, Year): 10/13/97

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): Dr. Mary E. Craig 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Dete filed (Month, Dey, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(15)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Catherine Dembosky

2. Date of Death: Month Oct. Day 6, Year 1997

3. Time of Death: 3:10 PM

4a. Facility Name (If not institution, give street and number): 202 South Somerset Avenue

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 219-07-7072

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 1, 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Soerset

10c. City, Town or Location: Crisfield

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 202 Somerset Avenue

10f. Zip Code: 21817

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Cook

16b. Kind of Business/Industry: Private

17. Father's Nama (First, Middle, Last): William Durand Hancock

18. Mother's Name (First, Middle, Maiden Surname): Ruby Clyde Morgan

19a. Informant's Name/Relationship (Type, Print): Phyllis Clark/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 202 S. Somerset Avenue, Crisfield, Maryland 21817

20a. Method of Disposition: 1☐ Buriel 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place):

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Servica Licensee: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediata Causa (Final disease or condition resulting in death)

a. Malignant Mesothelioma, Rt. Pleura, Adenoid — 4 yrs

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiatad evants resulting in death) Last

b.

Dua to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

Peptic Ulcer Disease

Essential Hypertension

Malnutrition 2° to Ca

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was case rafarrad to medical examinar? 1☐ Yes 2☒ No

26. Placa of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Gregorio M. Belloso M.D.

29c. License number: D29505

29d. Dete signed (Month, Day, Year): 10-8-97

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D. 5302 Chinaberry Dr., SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNA M. FRANCESCHINA

2. Date of Death (Month, Day, Year): OCTOBER 6, 1997

3. Time of Death: 8:15 AM

4a. Facility Name (If not institution, give street and number): 4201 GELDING LANE

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-48-6663

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 8, 1914

9. Birthplace (State or Foreign Country): Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Olney

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4201 Gelding Lane

10f. Zip Code: 20832

10g. Citizen of What Country?: Italy

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Gustav Mollenhauer

18. Mother's Name (First, Middle, Maiden Surname): (Unknown) Barsnik

19a. Informant's Name/Relationship (Type, Print): Angela L. Bauer/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4201 Gelding Lane, Olney, Maryland 20832

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 10/8/97

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Muriel H. Barber

22. Name and Address of Facility: Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Anemia	2 mos
Due to (or as a consequence of): b.	Vitamin B12 deficiency	6 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George Kenton MD

29c. License number: D 08695

29d. Date signed (Month, Day, Year): OCTOBER 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE S. KENTON, MD 10620 Georgia Ave Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31426

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARCELINA L. GARIN
2. Date of Death Month / Day / Year: OCTOBER 8, 1997
3. Time of Death: 1:30 pm
4a. Facility Name *(If not institution, give street and number)*: 3818 FEDERAL HILL ROAD
4b. City, Town, or Location of Death: JARRETTSVILLE
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 586-72-8674
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 43 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APRIL 6, 1954
9. Birthplace *(State or Foreign Country)*: PHILIPPINES

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: HARFORD
10c. City, Town or Location: JARRETTSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3818 FEDERAL HILL ROAD
10f. Zip Code: 21084
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* PHILIPPINE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YRS. College (1-4or 5+): 4 YRS.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARIAL WORK
16b. Kind of Business/Industry: PHYSICIANS OFFICE

17. Father's Name *(First, Middle, Last)*: ALFONSO LARATE
18. Mother's Name *(First, Middle, Maiden Surname)*: RESURRECCION BONGATO

19a. Informant's Name/Relationship *(Type, Print)*: RODOLFO E. GARIN
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3818 FEDERAL HILL ROAD JARRETTSVILLE MARYLAND 21084

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ST. JOHN'S CEMETERY
Date: OCT. 11, 1997
20c. Location - City or Town, State: LONG GREEN, MARYLAND
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: EVANS FUNERAL CHAPEL - BEL AIR, MD. 21050 3 NEWPORT DRIVE FOREST HILL, MARYLAND

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Advanced Carcinoma of the — couple
Due to (or as a consequence of):
b. Breast with Extensive Metastases — of weeks
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. to Liver, Pancreas, Brain, Lung
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cachexia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Manuel M
29c. License number: D19583
29d. Date signed *(Month, Day, Year)*: OCTOBER 9, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. MANUEL LARATTA 8 LAW ST. ABERDEEN, MARYLAND 21001

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12 DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31427

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN WILLIAM GILLESPIE

2. Date of Death Month Day Year: OCTOBER 7, 1997

3. Time of Death: 2:00 AM

4a. Facility Name *(If not Institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-62-4076

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 45 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 2, 1952

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Damascus

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9609 Faith Lane

10f. Zip Code: 20872

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Refuse Company

17. Fether's Name *(First, Middle, Last)*: J. W. Gillespie

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Helen M. Bailey

19a. Informant's Neme/Relationship *(Type, Print)*: Ann Gillespie/Sister

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 10401 Bethesda Church Rd., Damascus, Maryland 20872

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: True Gospel Cemetery

Date: 10/9/97

20c. Location - City or Town, State: Lisbon, Maryland

21. Signature of Funeral Service Licensee: ▶ Muriel H. Barber

22. Name end Address of Facility: Muriel H. Barber Funeral Home, P. O. Box 5038, Laytonsville, Maryland 20882

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Myocardial Infarction — 2 hrs

Due to (or as e consequenca ot):

Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in death) Last

b.

Due to (or es a consequence ot):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medicat Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edward Wilson MD

29c. License number: D19322

29d. Date signed *(Month, Day, Year)*: October 7, 1997

30. Name end address of person who completed cause of deeth (item 23a) (Type, Print): Edward Wilson, MD 9901 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31428

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Dorothy	M.	Hess	October 15, 1997	2AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Stella Maris	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-3369	1☐ M 2☒ F	80 Yrs.			10-2-17	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
924 Gorsuch Ave.	21218	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6	0	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unk. Brewer	Unk.

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mildred Bleach / daughter	1605 Weyburn Rd. Rosedale, MD 21237

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gardens of Faith	10-17-97	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Denis S. Kelly	Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)	a. Septicemia	
Due to (or as a consequence of):	Leukemia	Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Aspiration	Pneumonia
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature] MD	21550	10-15-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. [illegible] MD 2300 Belvedere Rd 21204.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
OCT 17 1997	▶ Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dorothy Hess

(3)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31429

Item: 27 per Physician G-752 10/17/97 reb *Certificate of Death*

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louis Stevenson Johns Sr.
2. Date of Death Month: October Day: 13, Year: 1997
3. Time of Death: 10:35a
4a. Facility Name *(If not institution, give street and number)*: 827 N. Arlington apt. 906
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 213-28-7862
6. Sex: XX 1☐M 2☐F
7. Age *(In yrs. last birthday)*: 65 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 28, 1932
9. Birthplace *(State or Foreign Country)*: BALTIMORE

Usual Residence of Decedent

10a. State: MD
10b. County: na
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: XX 1☒Yes 2☐No
10e. Street and Number: 827 N. ARLINGTON AVENUE APT. 906
10f. Zip Code: 21217
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: ARMY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 th; College (1-4or 5+): -
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MASONARY
16b. Kind of Business/Industry: BALTIMORE CITY

17. Father's Name *(First, Middle, Last)*: STEVENSON JOHNS
18. Mother's Name *(First, Middle, Maiden Surname)*: BETTY BROWN

19a. Informant's Name/Relationship *(Type, Print)*: LOUIS S. JOHNS, JR.-SON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4197 ADRIANNE WAY, BALTIMORE CO., MD 21133

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GARRISON FOREST VA
Date: 10=20=97
20c. Location - City or Town, State: OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: Gladys Wane
22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto. Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiopulmonary Arrest
Due to (or as a consequence of):
b. Chronic obstructive lung disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: J. Mikdashi, MD
29c. License number: D38046
29d. Date signed *(Month, Day, Year)*: 10/15/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mikdashi, J.A. 861 Park Ave Balto MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31430

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): FRANCES JANOCHA
2. Dete of Deeth: Month Oct, Dey 14, Yeer 1997
3. Time of Deeth: 1534 hrs
4a. Feciity Neme (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Deeth: BALTIMORE
4c. County of Deeth: N/A

Funeral Director

5. Sociel Security Number: 218-62-2798
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. iest birthday): 89 Yrs. | If Under 1 Year: Months, Deys | If Under 24 Hrs.: Hours, Min.
8. Dete of Birth (Month, Dey, Yeer): 09/08/1908
9. Birthpiece (State or Foreign Country): MD

Usuei Residence of Decedent

10a. Stete: MD
10b. County: BALTIMORE
10c. City, Town or Locetion: CATONSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 2003 WESTCHESTER AVENUE
10f. Zip Code: 21228
10g. Citizen of Whet Country?: U.S.A.
11. Mertei Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOUSE WIFE
16b. Kind of Business/Industry: OWN HOME
17. Father's Neme (First, Middle, Last): JOHN ZAKZREWSKI
18. Mother's Name (First, Middle, Meiden Sumeme): MARY ANN MARHEFKA
19a. Informent's Neme/Reietionship (Type, Print): THERESA KOHLWAY/ DAUGHTER
19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 2003 WESTCHESTER AVENUE CATONSVILLE, MD 21228
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): HOLY ROSARY CEMETERY
Dete: 10/17/97
20c. Locetion - City or Town, Stete: DUNDALK, MD
21. Signeture of Funerel Servica Licensee: Phillip Starks
22. Neme end Address of Feciity: STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. MYOCARDIAL INFARCTION — 1 DAY

Due to (or es e consequence of): SEPSIS — 2 DAYS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Piece of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Mamatha S. Ananth PGY3 RESIDENT
29c. License number: PO 8417
29d. Dete signed (Month, Dey, Yeer): Oct 14 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MAMATHA S. ANANTH 900 CATON AVE BALTIMORE MD 21229

State Registrar

31. Dete filed (Month, Dey, Yeer): OCT 17 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: FRANCES JANOCHA

REV 8

97-5876-027
ML

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31431

BRANDON JOHNSON Items: 23 part I, 27, 28a-f per MEO 11/6/97 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Brandon N. Johnson

2. Date of Death Month: OCTOBER Day: 13 Year: 1997

3. Time of Death: 8:18 PM

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 212-82-0745

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 22 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 5, 1975

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3002 Fallstaff Manor Ct. Apt. I

10f. Zip Code: 21209

10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled

16b. Kind of Business/Industry: Never worked

17. Father's Name (First, Middle, Last): Lloyd Johnson

18. Mother's Name (First, Middle, Maiden Surname): Catherine Robinson

19a. Informant's Name/Relationship (Type, Print): Mrs Catherine Johnson (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3002 Fallstaff Manor Ct. Apt. I Balto. Md. 21209

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley

Date: 10/20/97

20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SICKLE CELL CRISIS

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DUE TO SEPSIS AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 10/13/97

28b. Time of Injury: 8:81 P M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how Injury occurred: Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Lorien Nursing Home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 6334 Cedar Lane Columbia, Md.

29a. Certifier (Check only one) 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and ~~title of certifier~~

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): OCTOBER 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31432

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLAUDE JONES

2. Date of Death Month / Day / Year: OCTOBER 10 1997

3. Time of Death: 0843

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM 22 SOUTH GREENE STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-66-8922

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 5, 1957

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 2333 REISTERSTOWN RD.

10f. Zip Code: 21217

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION

16b. Kind of Business/Industry: BUILDING

17. Father's Name (First, Middle, Last): JAKE JONES

18. Mother's Name (First, Middle, Maiden Surname): WILLIE MAE TAYLOR

19a. Informant's Name/Relationship (Type, Print): BETTY GARRIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1536 GORSUCH AVE, BALT. MD. 21218

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEM.

Date: 10/15/97

20c. Location - City or Town, State: LANSDOWNE MD.

21. Signature of Funeral Service Licensee: Gary P. Marsh

22. Name and Address of Facility: GARY P. MARSH FUNERAL HOME P.A 270 FREDERICK PASS BALT. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPTICEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. PANCYTOPENIA

Due to (or as a consequence of):

c. SMALL CELL CARCINOMA

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD Resident

29c. License number: PD 9758

29d. Date signed (Month, Day, Year): OCTOBER 10 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Matthew M. Bruckel 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(1)

DHMH 16 Rev 6/95

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31433

ITEM# 24a PER DOC. FLM#G752 10/28/97 J.A. *Certificate of Death* Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN JOSEPH KRUSZEWSKI
2. Date of Death Month: OCTOBER Day: 8, Year: 1997
3. Time of Death: 4:30AM
4a. Facility Name *(If not institution, give street and number)*: 3107 DUDLEY AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-12-2693
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 6-22-25
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3107 DUDLEY AVENUE
10f. Zip Code: 21213
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: WWII ARMY
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 YEARS; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STEEL WORKER
16b. Kind of Business/Industry: BETH. STEEL

17. Father's Name *(First, Middle, Last)*: TROFIN KRUSZEWSKI
18. Mother's Name *(First, Middle, Maiden Surname)*: VICTORIA

19a. Informant's Name/Relationship *(Type, Print)*: MS. DONNA MATARACZO
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3107 DUDLEY AVENUE BALTO.MD. 21213

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GREEN MOUNT CEM.
Date: 10-10
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles B. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC LUNG CANCER	5 MONTHS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? AT GBMC 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R. Purtell Staff Physician
29c. License number: D19714
29d. Date signed *(Month, Day, Year)*: 10/16/97

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): MICHAEL PURTELL JHBVMC 4940 EASTERN Ave, BALTIMORE, Md 21224

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31434

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Maxine Kessell

2. Date of Death (Month, Day, Year): OCT 14, 1997

3. Time of Death: 4:20pm

4a. Facility Name *(If not institution, give street and number)*: Gladys Spellman Specialty Hosp. & Nursing Ctr.

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 232-46-3656

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 18, 1930

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2900 Mercy Lane

10f. Zip Code: 20785

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 3 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Lowell W. Payne

18. Mother's Name *(First, Middle, Maiden Surname)*: Nellie Bly Frame

19a. Informant's Name/Relationship *(Type, Print)*: Pauline V. Coleman/sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1109 Shore Dr. Edgewater, MD 21037

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc. | Date: 10/16/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Carcinoma of colon — Year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Vesico-colonic fistula

Vesico-ureteral reflux

Chronic Neutropenia 2° to radiation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward J. Yablonowitz, MD

29c. License number: D 25079

29d. Date signed *(Month, Day, Year)*: 10/15/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JON N. Yablonowitz, MD 7404 Executive Place, Seabrook, MD 20706

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997

32. Registrar's Signature: Gina Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

4

DHMH 16 Rev 6/95

RKD

97-5862-510

EDWARD KAIRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward John Kairis

2. Date of Death: Month OCTOBER Day 13, Year 1997

3. Time of Death: 3:50P.M.

4a. Facility Name (If not institution, give street and number): 5226 FREDCREST ROAD

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-12-9579

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): AUG 24, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5226 Fredcrest Road

10f. Zip Code: 21229

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elamantary/Secondary (0-12): 12

Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): Tool & Die Maker

16b. Kind of Business/Industry: Manufacturing

17. Fathar's Neme (First, Middle, Last): John Kairis

18. Mother's Name (First, Middle, Maiden Surname): UNK.

19a. Informant's Name/Relationship (Type, Print): Donna A. Farrell/step-granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 147 Liberty St. Linden, NJ 07036

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cramatory or other place): Metro Crematory, Inc.

Data: 10/15/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on aach line.

Approximate Interval Between Onset and Deeth

Immediata Causa (Final disease or condition resulting in death)

a. Hypertensive Atherosclerotic Cardiovascular Disease

Dua to (or as a consequanca of):

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated avents resulting in daath) Last

b.

Due to (or as a consequance of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evelleble prior to complation of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was cese refarrad to medical examiner? 1 [X] Yes 2 [ ] No

26. Placa of Daath (Check only ona)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): OCTOBER 14, 1997

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31436

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Buxton Kennedy

2. Date of Death (Month, Day, Year): October 13, 1997

3. Time of Death: 5:43 pm

4a. Facility Name (If not institution, give street and number): Doctors Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 212-24-7204

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 6, 1930

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14 Fayette Place

10f. Zip Code: 20770

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computerized Bookkeeping

16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Arthur C. Buxton

18. Mother's Neme (First, Middle, Maiden Surname): Helen Curfman

19a. Informant's Name/Relationship (Type, Print): Buford K. Kennedy/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 14 Fayette Place Greenbelt, MD 20770

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piace) Date: Metro Crematory, Inc. 10/15/97

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Sepsis	1 week
Due to (or as a consequence of): b.	Diverticular abscess	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest — Due to (or as a consequence of): c.		
Due to (or es e consequence of): d.		

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.: acute Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicide 4☐ Homlcide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physicfan:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: David Granite MD

29c. License number: D17572

29d. Date signed (Month, Day, Year): 10/14/97

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): D. Granite MD 115 Centerway Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Tisha Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Ruth Buxton Kennedy

18

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item:7 per FH G-752 10/17/97 dh
Item:29d per MD G-752 10/17/97 dh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31437

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AMELIA M. KANE
2. Date of Death (Month, Day, Year): October 8, 1997
3. Time of Death: 10:30 pm
4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-24-7494
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~21230~~ 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 19,1906
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 600 LIGHT STREET - APT-825
10f. Zip Code: 21230
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAITRESS
16b. Kind of Business/Industry: BAKERY

17. Father's Name (First, Middle, Last): GEORGE KOEMIG
18. Mother's Name (First, Middle, Maiden Surname): LENA HUFFMAN

19a. Informant's Name/Relationship (Type, Print): JOAN A. ZINNERT(DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 80 MARIANNE DRIVE - HANOVER, PA. 17331

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY
Date: 10/13/97
20c. Location - City or Town, State: BALTIMORE

21. Signature of Funeral Service Licensee: Teresa L Klug
22. Name and Address of Facility: HUBBARD FUNERAL HOMR INC. 4107 WILKENS AVENUE - BALTIMORE, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Coronary Artery Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D 15504
29d. Date signed (Month, Day, Year): 10/8/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium Md 21093

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: AMELIA KANE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31438

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lloyd Linwood Lawrence
2. Date of Death: Month 10 Day 13 Year 97
3. Time of Death: 17:20
4a. Facility Name (If not institution, give street and number): Deaton University of Md. Medicine
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 231-26-2045
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 8, 1927
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 611 S. CHARLES
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: BUILDING

17. Father's Name (First, Middle, Last): JAMES LAURENCE
18. Mother's Name (First, Middle, Malden Surname): ANNIE EDWARDS

19a. Informant's Name/Relationship (Type, Print): DENISE BAKER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3033 WALBROOK AVE. BALT. MD. 21216

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GARRISON-FOREST
Date: 10/17/97
20c. Location - City or Town, State: OWINGS MILLS MD.

21. Signature of Funeral Service Licensee: Gary P. Marca
22. Name and Address of Facility: GARY P. MARCA FUNERAL HOME P.A. 270 FREDHILTON PASS BALT. MD. 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finat disease or condition resulting in death)
e. Pneumonia — one week

Due to (or es a consequence of):
b. Stroke — Five years

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D38675
29d. Date signed (Month, Day, Year): 10/14/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JOEL MESHULAM 1147 S HANOVER ST BALTIMORE MD 21230

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(4)

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Sacha Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31439

NAME: NELSON LUTE

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nelson Lute

2. Date of Death Month Day Year: OCTOBER 15, 1997

3. Time of Death: 9 A.M.

4a. Facility Name *(If not institution, give street and number)*: VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death:

Funeral Director

5. Social Security Number: 215-38-7704

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPTEMBER 13, 1916

9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: Md

10b. County: Anne Arundel

10c. City, Town or Location: Crownsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1253 Generals Highway

10f. Zip Code: 21032

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Dates: 1935-1965

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elamantary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Master Sargeant

16b. Kind of Business/Industry: Military

17. Father's Name *(First, Middle, Last)*: Hal Lute

18. Mother's Name *(First, Middla, Maiden Surname)*: Brookie Stevens

19a. Informant's Name/Relationship *(Type, Print)*: Delores L. Lute/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1253 Generals Hwy., Crownsville, Md 21032

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Md. Veterans Cem.

Date: 10/20

20c. Location - City or Town, State: Crownsville Md

21. Signature of Funeral Service Licensee: Patrick J. Arnold

22. Name and Address of Facility: Hardesty Funeral Home 12 Ridgely Ave., Annapolis Md 21401

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth)

a. LEFT LOWER LOBE PNEUMONIA

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying ceusa given in Part I.

ARTERIOSCLEROTIC HEART DISEASE WITH ATRIAL FIBRILLATION, ANEMIA OF CHRONIC DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabie prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Carolina Custodio

29c. Licansa number: D-15628

29d. Data signed *(Month, Day, Year)*: 10/15/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CAROLINA CUSTODIO, M.D. 9600 NORTH POINT RD FORT HOWARD, MD 21052

State Registrar

31. Date filed *(Month, Day, Yeer)*: OCT 17 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

97-5904-005
CIP
WINIFRED THELMA LAYTON
Items:23a part I,27 per MEO G-752 10/22/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Winifred Thelma Layton

2. Date of Death (Month, Day, Year): OCTOBER 15, 1997

3. Time of Death: 7:24AM

4a. Facility Name (If not institution, give street and number): 6105 DEERBROOK ROAD

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 233-34-5848

6. Sex: 1☐ M X☐ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 14, 1915

9. Birthplace (State or Foreign Country): West Virginia

Usual Residance of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Catonsville

10d. Inside City Limits: 1☐ Yes X☐ No

10e. Street and Number: 6105 Deerbrook Road

10f. Zip Coda: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired): School Teacher

16b. Kind of Business/Industry: Baltimore County Public Schools

17. Father's Name (First, Middle, Last): Wilson Luther Spring

18. Mother's Name (First, Middle, Maiden Surname): Zula Elizabeth Wisner

19a. Informant's Name/Relationship (Typa, Print): Wanda M. Pease/sister

19b. Malling Addresa (Street and Number or Rural Route Numbar, City or Town, State, Zip Coda): 412 Baldwin Park Dr. Westminster, MD 21157

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Spacify)

20b. Place of Disposition (Nama of cemetery, crematory or other place): Mt. Nebo Cemetery

Date: 10/18/97

20c. Location - City or Town, State: Great Cacapon, WV

21. Signature of Funeral Service Licensee: Dawn F. McDonald
Dawn F. McDonald

22. Name and Address of Facility: MacNabb Funeral Home, P.A.
301 Frederick Rd. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisf only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in daath)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE WITH ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last
b.
Dua to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco usa contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home ☒ Residance 6☐ Other (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☐ **Certifying Physician**: To tha best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☒ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signature and title of certifier: Stephen S. Radentz, MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): OCTOBER 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31441

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clara LHOTSKY
2. Date of Death Month Day Year: October 11 1997
3. Time of Death: 2:52 pm.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217206987
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 24, 1925
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residance of Dacedant

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: ESSEX
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 329 WORTON ROAD
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedant Evar In U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: WHITE

15. Dacedant's Education (Specify only highast grada complatad): Elamentary/Secondary (0-12): 12 | Collega (1-4or 5+): 0
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): HOMEMAKER
16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Nama (First, Middla, Last): F. CHARLES FRANZ
18. Mothar's Nama (First, Middla, Maidan Sumama): ALICE L. EASTWOOD

19a. Intormant's Name/Ralationship (Type, Print): JOHN J. LHOTSKY SR. / HUSBAND
19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 329 WORTON ROAD ESSEX MD 21221

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of cematary, cramatory or othar placa): HOLY REDEEMER
Data: 10/15/97
20c. Location - City or Town, Stata: BALTIMORE, MD

21. Signature of Funeral Service Licensee ▶
22. Nama and Addrass of Facility: 1211 CHESACO AVE 21237 CVACH/ROSEDALE FUNERAL HOME

Physician /Medical Examiner

23a. Part I. Entar the disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart tailura. List only ona causa on aach lina.

Approximata Intarval Between Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)
a. Severe pulmonary emphysema — Years
Due to (or as a consaquanca of):
b. Hypoxemia — years.

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last
Due to (or as a consaquance of):
c. acute respiratory failure — sudden
Due to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to compiation of causa of death? 1☐ Yas 2☐ No

25. Was casa ratarrad to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death (Check only ona) Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☒ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Cartifying Physician**: To tha best of my knowiedga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and titla of cartifiar ▶
29c. Licansa number: D10613
29d. Data signed (Month, Day, Year): 10-14-97

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Type, Print): RAFAEL PEREZ-MERA, M.D. 404-406 EASTERN BLVD., BALTIMORE, MD 21221

State Registrar

31. Data filad (Month, Day, Year): OCT 17 1997
32. Registrar's Signature ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31442

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Margaret McKaig
2. Date of Death: Month October Day 16 Year 1997
3. Time of Death: 12:00am
4a. Facility Name (If not institution, give street and number): Manor Care Health Services - Towson
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-05-3415
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 4, 1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 509 E. Joppa Road
10f. Zip Code: 21286
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: Accounting

17. Father's Name (First, Middle, Last): William Lawrence May
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Schultz

19a. Informant's Name/Relationship (Type, Print): Barbara Summerhill/Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Rose St., Timonium, MD 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery
Date: 10/18/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Bryan W. Clark
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Senile Dementia
Due to (or as a consequenca of):
b. Hypothyroidism
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Malnutrition
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D42736
29d. Date signed (Month, Day, Year): October 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ayman Akkad, MD 7600 Osler Drive, suite 203, Towson, MD 21204

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31443

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles J. Murphy
2. Date of Death (Month, Day, Year): October 15, 1997
3. Time of Death: 12:15 PM
4a. Facility Name (If not institution, give street and number): 1004 Haverhill Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-26-3016
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 18, 1931
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: n/a
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1004 Haverhill Road
10f. Zip Code: 21229
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): auto mechanic
16b. Kind of Business/Industry: service center

17. Father's Name (First, Middle, Last): Robert Louis Murphy, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Edith Goetz

19a. Interment's Name/Relationship (Type, Print): Mary R. Walls - daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1004 Haverhill Rd Baltimore, MD 21229

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Cemetery
Date: 10/18/97
20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: ▶ Ann Zink
22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Lung Carcinoma — unknown
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Metastasis

23b. **Did tobacco use contribute to the cause of death?** 1 [✓] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ MD
29c. License number: D27569
29d. Date signed (Month, Day, Year): 10/16/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen Hettleman 1838 Greene Tree Rd #300

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: ▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

REB 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31444

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS L. MILLER
2. Date of Death Month / Day / Year: Oct 16, 1997
3. Time of Death: 3 55 AM
4a. Facility Name *(If not institution, give street and number)*: MANOR CARE Health Services
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-09-2587
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 24, 1911
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Baltimore
10c. City, Town or Location: Hillendale
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1310 B Colbury Rd.
10f. Zip Code: 21239
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Personel Director
16b. Kind of Business/Industry: Baltimore City Police

17. Father's Name *(First, Middle, Last)*: Elmer H. Miller
18. Mother's Name *(First, Middle, Maiden Surname)*: AGNES E. Krieger

19a. Informent's Name/Relationship *(Type, Print)*: ELIZABETH MILLER / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1310B Colbury Rd. Baltimore Md. 21239

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Green Mount Cemetery | Date: Oct 17 1997
20c. Location - City or Town, State: Baltimore Md.

21. Signature of Funeral Service Licensee: Robert W. Rowe Jr.
22. Name and Address of Facility: EVANS CHAPEL of Chimes 2325 York Rd Timonium Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Aspiration pneumonitis — 12 hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. end stage Dementia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jeffrey A Cool MD
29c. License number: D34650
29d. Date signed *(Month, Day, Year)*: 10/16/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Jeffrey Cool Good Samaritan Professional Bldg Balto. Md

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 31445

Items:1,23a part II per MD 10/17/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
WILBERT	STANLEY	MANSBERGER	1 OCTOBER 1997	12:24 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Saint Joseph Medical Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-07-7193	1☒ M 2☐ F	82 Yrs.			08/17/1915	WV

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	TOWSON	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
955 ELLENDALE DRIVE	21286	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes ☒ No If Yes, Give Year or Dates:	1☐ Yes ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	CHIEF METALIST	BETHLEHEM STEEL

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Melden Surname)
HARRY S. MANSBERGER	LOLA BROWN

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JANE MANSBERGER/WIFE	955 ELLENDALE DRIVE TOWSON, MD 21286

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	OAKLAWN CEMETERY	10/3/97	BALTIMORE, MD

21. Signature of Funeral Service Licensee: ▶ Phillip Stouls

22. Name and Address of Facility: BRADLEY-ASHTON-DABROWSKI-MATTHEWS FUNERAL HOME, INC 2134 WILLOW SPRING ROAD DUNDALK, MD 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death)	e. SEPTIC SHOCK	HOURS
Due to (or as a consequence of):	URINARY TRACT INFECTION	HOURS
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest — Due to (or as e consequence of):	b. RESPIRATORY FAILURE	HOURS
Due to (or as a consequence of):	c. RENAL FAILURE	HOURS
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LACTIC ACIDOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of deeth?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or Investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and menner stated.

29b. Signature end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
▶ Richard L. Linthicum MD	D31826	10-1-97

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): RICHARD L. LINTHICUM, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrar's Signature
OCT 16 1997	▶ Sha Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31446

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Orland Owens

2. Date of Death Month: Oct. Day: 14 Year: 1997

3. Time of Death: 6:00 Am

4a. Facility Name *(If not institution, give street and number)*: 2315 Chelsea Terrace

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-22-2225

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 6-9-1927

9. Birthplace *(State or Foreign Country)*: Balto. Md

Usual Residance of Decedent

10a. State: md

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2315 Chelsea Terrace

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Navar Marriad 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yas 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Afro American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life, DO NOT use retired)*: Painter

16b. Kind of Business/Industry: Self-employed

17. Father's Name *(First, Middle, Last)*: Leonard Owens Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Viola Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Leonard Owens Jr. (Brother)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4801 Valley Forge Rd. Randallstown Md. 21133

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Garrison Forest

Date: 10/20/97

20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funaral Service Licansee: Joseph L. Russ

22. Name and Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HEAD + NECK CARCINOMA — 3 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Hyang Park M.D.

29c. Licansa number: D09828

29d. Data signed *(Month, Day, Year)*: 10/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): So Hyang Park Baltimore VA Hospital 10 N. Greene St. 21201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas I. Peters

2. Date of Death: Month: October; Day: 14; Year: 1997

3. Time of Death: 10:55p

4a. Facility Name (If not institution, give street and number): 1415 Carswell Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 217-22-9715

6. Sex: 1☐M 2☐F XX

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-11-29

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: Md.

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1415 Carswell Street

10f. Zip Code: 21218

10g. Citizen of What Country: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: Green Spring Diary

17. Father's Name (First, Middle, Last): Charles Peters

18. Mother's Name (First, Middle, Maiden Surname): Evelyn Crawford

19a. Informant's Name/Relationship (Type, Print): Judy M. Peters

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1415 Carswell Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore Nat'l Cem.

Date: 10-20-97

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Francis [illegible]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Anoxic Encephelopathy	8 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Seizures	8 days
Due to (or as a consequence of):		
	c. myocardial infarction - acute	8 days
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Hypertension

Diabetes Mellitus, Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year): N/A

28b. Time of Injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hillary Woodson, MD

29c. License number: AU 4176-435-WA 386

29d. Date signed (Month, Day, Year): October 14, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HILLARY WOODSON, MD; UNIV OF MD - DEPT OF FAM MEDICINE, 29 S. PACA ST, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Peters, Thomas I.

1+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31448

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WANDA CATHERINE PILACHOWSKI
2. Date of Death Month, Day, Year: OCTOBER 16, 1997
3. Time of Death: 10:10a
4a. Facility Name *(If not institution, give street and number)*: GILCHRIST AT GBMC
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE CO.

Funeral Director

5. Social Security Number: 216-20-2979
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 6-12-26
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 943 S. BOULDIN STREET
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 YEARS | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BARTENDER
16b. Kind of Business/Industry: WALT'S CAFE

17. Father's Name *(First, Middle, Last)*: JOHN BLUSIEWICZ
18. Mother's Name *(First, Middle, Maiden Surname)*: SABINA HONASKI

19a. Informant's Name/Relationship *(Type, Print)*: MRS. WENDY LEMBACH
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6708 GARVEY RD. BALTO. MD. 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: ST. STANISLAUS CEM.
Date: 10-19
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. metastatic ovarian cancer — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:
b.
Due to (or es a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: None
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed *(Month, Day, Year)*: October 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto, md 21204

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Wanda Pilachowski 10:10AM 10/16/97

RLB 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris Olga Pilgrim
2. Date of Death (Month, Day, Year): Oct. 13 1997
3. Time of Death: 8:30pm
4a. Facility Name (If not institution, give street and number): 3033 Acton Rd.
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-24-8448
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 14, 1914
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3033 Acton Rd.
10f. Zip Code: 21234
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12yrs. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home
17. Father's Name (First, Middle, Last): Theodore Linck
18. Mother's Name (First, Middle, Maiden Surname): Margaret Rehbein
19a. Informant's Name/Relationship (Type, Print): Martha Morris
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3033 Acton Rd. Baltimore, Md 21234
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Parkwood Cemetery
Date: Oct. 16 1997
20c. Location - City or Town, State: Parkville, Maryland
21. Signature of Funeral Service Licensee: ▶ Krista S. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Ceuse (Final disease or condition resulting in death): a. Adenocarcinoma of the lung

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ David R Reichert
29c. License number: D31008
29d. Date signed (Month, Day, Year): 10-15-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. David Reichert 9105 Franklin Square Drive Suite 206

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

T

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HATTIE REYNOLDS
2. Date of Death — Month: 10 Day: 14 Year: 97
3. Time of Death: 10 25 AM
4a. Facility Name (If not institution, give street and number): LIBERTY MEDICAL CENTER
4b. City, Town, or Location of Death: BALT. MD.
4c. County of Death:

Funeral Director

5. Social Security Number: 213-30-5411
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 24, 1929
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2304 N. Fulton Ave.
10f. Zip Code: 21217
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Glass Bottle Maker
16b. Kind of Business/Industry: Maryland Glass

17. Father's Name (First, Middle, Last): Pearlie Marsh
18. Mother's Name (First, Middle, Maiden Surname): Leslie Johnson

19a. Informant's Name/Relationship (Type, Print): Sandy Corbin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217: 2304 N. Fulton Ave. Baltimore, Maryland

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): King Memorial Park — Date: 10/17
20c. Location - City or Town, State: Baltimore Co. MD.

21. Signature of Funeral Service Licensee: Kevin Parker
22. Name and Address of Facility: Kevin A. Parker Funeral Home, 3512 Frederick Ave. Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Sepsis.
Due to (or as a consequence of):
b. Gangrene Rt. Foot
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes Mellitus Long Standing.
Due to (or as a consequence of):
d. Status Post. Tracheostomy + Feeding Gastrostomy

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension and Atrial fibrillation
Seven episodes of C. V. A and
Hemiparesis. Diabetes Mellitus.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A. Qureshi M.D
29c. License number: D12870.
29d. Date signed (Month, Day, Year): 10-14-97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ABDUL G. QURESHI, M.D. 501 DOLPHIN ST. BALT. MD 21217

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31451

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Stewart Ruckle, SR.
2. Date of Death Month / Day / Year: Oct 11, 1997
3. Time of Death: 7 45 AM
4a. Facility Name *(If not institution, give street and number)*: 10015 Harford Rd.
4b. City, Town, or Location of Death: Carney
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-18-3112
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 7, 1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Carney
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10015 Harford Rd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Representative
16b. Kind of Business/Industry: TROPHIES

17. Father's Name *(First, Middle, Last)*: THOMAS RUCKLE
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret McGeeney

19a. Informant's Name/Relationship *(Type, Print)*: DOROTHY RUCKLE / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10015 Harford Rd Carney Md 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: OAK Lawn Cemetery — Date: Oct 14 1997
20c. Location - City or Town, State: Balto. Md

21. Signature of Funeral Service Licensee: Robert W. Evans
22. Name and Address of Facility: Evans Chapel of Memories 8800 Harford Rd Balto. Md.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE CARDIOMYOPATHY
Due to (or as a consequence of):
b. ASBESTOSIS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CARDIAC ARRYTHMIAS
Due to (or as a consequence of):
d. CORONARY ARTERY DISEASE

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Syed Mahmood M.D.
29c. License number: D45921
29d. Date signed *(Month, Day, Year)*: October 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED MAHMOOD 4-C North Ave Suite 424 Bel Air MD 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31452

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TUDOR A. RANDELL

2. Date of Death Month: October Day: 12 Year: 1997

3. Time of Death: 1425

4a. Facility Name *(If not institution, give street and number)*: Howard County General Hospital

4b. City, Town, or Location of Death: Columbia

4c. County of Death: Howard County

Funeral Director

5. Social Security Number: 218-36-0122

6. Sex: 1☑M 2☐F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 14,1919

9. Birthplace *(State or Foreign Country)*: United Kingdom

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard County

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐Yas 2☐No X

10e. Street and Number: 5414 Spindrift Place

10f. Zip Code: 21045

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married XX Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2XX No If Yes, Give Yaer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - American Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12): unknown / College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: advisor

16b. Kind of Buainess/Industry: scientific/aviation

17. Fathar's Nama *(First, Middla, Last)*: Griffith James Randell

18. Mother's Nama *(First, Middle, Maiden Sumama)*: Rose Maude Wibley

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Jean Randell/spouse

19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, State, Zip Code)*: 5414 Spindrift Place, Columbia, MD 21045

20a. Method of Disposition: 1☐Burial 2XX Cramation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Placa of Disposition *(Neme of cemetery, cremetory or other piece)*: Metro Crematory

Date: 14OCT97

20c. Location - City or Town, Stata: Catonsville, Maryland

21. Signature of Funeral Service Licensee: M00535

22. Nama and Addrass of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral infarction — 4 days

Due to (or as a consequenca of):

b. Transtentorial herniation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes an autopay performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yas 2☑No

26. Place of Death *(Check only ona)*: Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Naturei 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Mahnaz Rahbar, M.D.

29c. Licanse number: MD # D48026

29d. Data signed *(Month, Day, Year)*: October 12 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Mahnaz Rahbar 2 knoll.. North Drive Columbia, MD 21045

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(18)

DHMH 16 Rev 6/95

97-5896-005
ML

ANTOINETTE SIEJACK RUPP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antoinette Siejack Rupp
2. Date of Death (Month, Day, Year): OCTOBER 15 1997
3. Time of Death: 7:20 AM
4a. Facility Name (If not institution, give street and number): HANOVER PIKE AND 5th. AVENUE
4b. City, Town, or Location of Death: UPPERCO
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-48-4445
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11 47
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Upperco
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5541 Emory Road
10f. Zip Code: 21155
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, White, etc.: Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Analyst
16b. Kind of Business/Industry: U.S. Customs

17. Father's Name (First, Middle, Last): Theodore Siejack
18. Mother's Name (First, Middle, Maiden Sumame): Julia Siminski

19a. Informant's Name/Relationship (Type, Print): David Rupp (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5541 Emory Rd. Upperco, Md. 21155

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or other place): Sacred Heart Jesus | Data: Oct. 18
20c. Location - City or Town, State: Dundalk, Maryland

21. Signatura of Funeral Service Licensee: Mark A. Signach
22. Nama and Address of Facility: W. Dabrowski/Chojnacki F.H.P.A. 1005 Dundalk Ave. Baltimore, Md. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each lina.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings availabia prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Homa 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Naturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer): 10-15-97
28b. Time of Injury: 0450 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Driver auto - auto collision
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify): Roadway
28f. Location (Street and Number or Rurel Route Number, City or Town, State): Hanover Pike

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: O.C.M.E.
29d. Data signed (Month, Day, Year): OCTOBER 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David L Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(8)

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State of Maryland / Department of Health and Mental Hygiene

Items: 7,12 per F.H.G-752 10/17/97 reb

Certificate of Death

Reg. No. 97 31454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alexander A. Spivery

2. Date of Death Month: October Day: 12 Year: 1997

3. Time of Death: 1:25 AM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: N/a

Funeral Director

5. Social Security Number: 217-20-4955

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 ~~44~~ Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-22-25

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1100 Bolton St

10f. Zip Code: 21201

10g. Citizen of What Country?: U.SA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes ~~2 ☒ No~~ If Yes, Give Yeer or Dates: 1944 1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12th

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tailor

16b. Kind of Business/Industry: Cleaners

17. Father's Name (First, Middle, Last): Alexander Spivery

18. Mother's Name (First, Middle, Maiden Surname): Gladys Spivery

19a. Informant's Name/Relationship (Type, Print): Betty Spivery - Wife

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 1100 Bolton Street Apt 217 Balto, Md

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Garrison Forest Vet

Date: 10-17-97

20c. Location - City or Town, State: Owings Mills, Md 21215

21. Signature of Funeral Service Licensee: Dale March

22. Name end Address of Feciility: March F.H. West 4300 Wabash Avenue Balto, Md

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part ii. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☑ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☑ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 89247

29d. Date signed (Month, Dey, Year): 10/13/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): NSeKenen Kolongo, M.D. C/o Maryland General Hospital.

State Registrar

31. Dete filed (Month, Dey, Year): OCT 17 1997

32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, pege 2 should be detached for use as the burial-transit permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Alexander Spivery

64

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31455

Item:19a per FH G-752 10/17/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIAM LEONA SCHAMBERGER
2. Date of Death Month: 10 Day: 13 Year: 97
3. Time of Death: 2215
4a. Facility Name *(If not institution, give street and number)*: Oak Crest Medcial Center
4b. City, Town, or Location of Death: Parkville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-18-7526
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 31, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8832-S138 Walther Blvd.
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+): n/a
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manufacturer
16b. Kind of Business/Industry: Eskay Meats

17. Father's Name *(First, Middle, Last)*: Francis Prosniewski
18. Mother's Name *(First, Middle, Maiden Surname)*: Blanche Gabriel

19a. Informant's Name/Relationship *(Type, Print)*: Leo Prosniewski,Jr./Nephew ~~Ronald Prosser/Nephew~~
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2511 Claret Drive, Fallston, MD 21047

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Dulaney Valley Mausoleum | Date: 10/16/97
20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary
22. Name and Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. COPD - Chronic Obstructive Pulmonary Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Atrial Fibrillation
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D 50620
29d. Date signed *(Month, Day, Year)*: 10/14/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRIAN EAGLE, MD 8800 Walther Blvd, Oak Crest Med Ctr, Parkville, MD 21234

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31456

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Szymborski
2. Date of Death Month Day Year: October 10, 1997
3. Time of Death: 5:08 pm
4e. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-52-8531
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6-29-49
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTO. CO.
10c. City, Town or Location: DUNDALK
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7377 EDSWORTH ROAD
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Date: NAVY WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): +2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LONGSHOREMAN
16b. Kind of Business/Industry: ILA

17. Father's Name (First, Middle, Last): VINCENT E. SZYMBORSKI
18. Mother's Name (First, Middle, Maiden Surname): ELEANOR ZAWORSKI

19a. Informant's Name/Relationship (Type, Print): MRS. ELEANOR SZYMBORSKI
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7377 EDSWORTH RD. BALTO. MD. 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT CEMETERY
Date: 10-13
20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles B. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death)
a. Liver Failure
Due to (or as a consequence of):
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
b. Aspiration Pneumonia
Due to (or as a consequence of):
c. Lung Abscess
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Dehydration, Encephalopathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of ceuse of deeth? 1☒ Yes 2☐ No

25. Was cese referred to medical examiner? 1☒ Yes 2☐ No
26. Plece of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier
29c. License number: D26233
29d. Date signed (Month, Dey, Year): October 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis Kuhajda, MD JHBMC 4940 Eastern Ave Balt, MD 21224

State Registrar

31. Date Filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

pages: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31457

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): George Anthony Shaffer
2. Date of Deeth — Month: October Dey: 14, Year: 1997
3. Time of Deeth: 12 30 AM
4e. Fecility Neme (If not institution, give street end number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Deeth:

Funeral Director

5. Socisl Security Number: 213-14-4914
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthday): 78 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Sept. 24 1919
9. Birthplace (Stete or Foreign Country): Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 2932 Willoughby Rd.
10f. Zip Code: 21234
10g. Citizen of Whet Country?: USA
11. Meritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12yrs — College (1-4or 5+): 2yrs
16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Right of way assistant
16b. Kind of Business/Industry: Baltimore County Land Acquisition
17. Fether's Name (First, Middle, Lest): Wilson Shaffer
18. Mother's Name (First, Middle, Maiden Surneme): Mary C. Bangert
19a. Informant's Neme/Relationship (Type, Print): Stephen Shaffer
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3718 Timahoe Circle Balto. Md. 21236
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Ptece of Disposition (Neme of cemetery, cremetory or other pleca): Parkwood Cemetery — Date: Oct. 17 1997
20c. Location - City or Town, Stete: Parkville Maryland
21. Signeture of Funeral Service Licensee: Krista S. Wells
22. Neme end Address of Fecility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or comptications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediate Ceuse (Finel disease or condition resulting tn death): e. Pneumonia

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest:

b.

Due to (or as e consequence of):

c.

Due to (or es e consequenca of):

d.

Part tt. Other elgnlftcant conditions contributing to death but not resulting in the underlying cause given in Part I.: Decompensated Heart Failure

23b. Dtd tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings evellable prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Ptace of Death (Check only one): Hospital: 1 [X] tnpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturat 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28e. Dete of tnjury (Month, Dey Yeer)

28b. Time of tnjury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how tnjury occurred

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certtfying Physlcien: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 [ ] Medlcal Examtner: On the basis of exemtnetion end/or investigetion, in my opinion, deeth occurred at the time, dete end pleca, and due to the cause(s) end menner stated.

29b. Signature end titie of certifier: [signature]

29c. License number: 89266

29d. Dete signed (Month, Dey, Yeer): 10/14/97

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Ashraf Mostafa, M.D. c/o Maryland General Hospital.

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 17 1997

32. Registrer's Signeture: Julia Davidson-Randall

DRMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after deeth.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

George Shaffer

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31458

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward L. Tewey
2. Date of Death: Month: October Day: 8 Year: 1997
3. Time of Death: 1:00 am
4a. Facility Name (If not institution, give street and number): Stella Maris
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 705-05-7401
6. Sex: 1 [X] M 2 [ ] F
7. Age (in yrs. last birthday): 96 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Oct. 28, 1900
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Perry Hall
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8929 Kilkenny Circle
10f. Zip Code: 21236
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12yrs. College (1-4or 5+): 2yrs.
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Claims Investigator
16b. Kind of Business/Industry: B & O Railroad

17. Father's Name (First, Middle, Last): John L Tewey
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Leukehausen

19a. Informant's Name/Relationship (Type, Print): Edward J. Tewey
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8929 Kilkenny Circle Perry Hall Md. 21236

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Spacify)
20b. Place of Disposition (Name of cematary, crematory or other piece): Holy Redeemer Cemetery. Date: Oct. 11 1997
20c. Location - City or Town, State: Baltimore Maryland
21. Signature of Funeral Service Licensee: Kenta S. Wells
22. Name and Address of Facility: Evans Chapel of Memories 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal failure
Due to (or as a consequence of): Hydrocephalus
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure, Arteriosclerosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. Other: [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Eddie Nakhuda MD
29c. License number: D 15504
29d. Data signed (Month, Day, Year): Oct. 10, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: EDWARD TEWEY

6

RKD

97-5882-510

BENJAMIN WILBURN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31459

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Benjamin Wilburn, III

2. Date of Death Month / Day / Year: OCTOBER 14, 1997

3. Time of Death: 4:30P.M.

4a. Facility Name *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: NA

Funeral Director

5. Social Security Number: 220-98-6271

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 16 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Yeer)*: 06-18-81

9. Birthplaca *(Steta or Foreign Country)*: Md

Usual Residence of Decedent

10a. State: Md

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1722 North Broadway Street

10f. Zip Code: 21213

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede compleated)*

Elemantary/Secondary (0-12): 9th Grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: Unemployed

17. Father's Name *(First, Middle, Last)*: Benjamin Wilburn, Jr.

18. Mothar's Name *(First, Middle, Maiden Surneme)*: Bernice Davis

19a. Informant's Name/Relationship *(Type, Print)*: Bernice Davis

19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 1722 North Broadway Baltimore, Maryland 21213

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Voshell Mem. Gardens

Date: 10-20-97

20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensae: Francis J. Gr[illegible]

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Daath

Immediate Ceuse (Finel disease or condition resulting in death)

a. Gunshot Wounds of chest and arm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uaa contribute to the cauae of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No

24b. Ware autopsy findings available prior to completion of cause of death? 1☒Yes 2☐No

25. Was case refarrad to medical examiner? 1☒Yes 2☐No

28. Place of Death *(Check only one)*

Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☐Residence 6☐Othar *(Specify)*

27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicida 4☒Homicide 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury *(Month, Day Year)*: 10-14-97

28b. Time of Injury: 15-15 M

28c. Injury at Work? 1☐Yes 2☒No

28d. Dascribe how injury occurred: Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street

28f. Location *(Street end Number or Rurel Route Number, City or Town, Steta)*: 1700 Blk N. Broadway

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated. XX **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title ~~of certifier~~: [signature]

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Yeer)*: OCTOBER 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Yeer)*: OCT 17 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31460

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtle M. Zelinski
2. Date of Death (Month, Day, Year): Oct. 14 1997
3. Time of Death: 4:30pm
4a. Facility Name (If not institution, give street and number): Good Samaritan Nursing Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: —

Funeral Director

5. Social Security Number: 212-01-3127D
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 102 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 30 1895
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: —
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2741 Miles Ave.
10f. Zip Code: 21211
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9yrs. College (1-4or 5+): —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): William Montroy
18. Mother's Name (First, Middle, Maiden Surname): Josephine Jondreau

19a. Informant's Name/Relationship (Type, Print): Josephine D'Onofrio
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5702 Fenwick Ave. Baltimore Md 21239

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery | Date: Oct. 16 1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Krista L. Wells
22. Name and Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. Acute cerebrovascular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Breast carcinoma
ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D35305
29d. Date signed (Month, Day, Year): 10-17-97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Robert Hsiao 5601 Loch Raven Blvd.

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDNA M ZUKOWSKI
2. Date of Death (Month, Day, Year): OCTOBER 15 1997
3. Time of Death: 3:20AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-40-2340
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 9-23-19
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7269 BRIDGEWOOD DRIVE
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 YEARS | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): LEONARD NEAD
18. Mother's Name (First, Middle, Maiden Surname): LIZZIE SCHADER

19a. Informant's Name/Relationship (Type, Print): MISS LEONA SHAW
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7269 BRIDGEWOOD DRIVE BALTO. MD. 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SACRED HEART OF JESUS CEM | Date: 10-18
20c. Location - City or Town, State: BALTO. CO. MD.

21. Signature of Funeral Service licensee: Walter R. Kaczorowski
22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE. BALTO. MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — 9 DAYS
Due to (or as a consequence of):
b. METASTATIC LUNG CANCER — 1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mandeep Sandhu MD
29c. License number: PO 10876
29d. Date signed (Month, Day, Year): OCTOBER 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MANDEEP SANDHU JOHNS HOPKINS HOSPITAL, 600 N. WOLFE STREET, BALTIMORE, MD-21287

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997
32. Registrar's Signature: ▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To be completed by Funeral Director

Medical Certification: To be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31462

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Doris A. Arnold
2. Date of Death Month: Oct Day: 14 Year: 1997
3. Time of Death: 1430hrs
4a. Facility Name *(If not institution, give street and number)*: St. Agnes Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-32-9344
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Apr 14, 1916
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Lansdowne
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 30 Third Avenue
10f. Zip Code: 21227
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Walter Hoffman
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Brooks

19a. Informant's Name/Relationship *(Type, Print)*: Doris Weedon Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28 Third Avenue Lansdowne, Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore Nat. Cemetery — Date: 10/17
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Paul W Hagan
22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne, 2719 Hammonds Ferry Road Lansdowne, Maryland 21227

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE MYOCARDIAL INFARCTION — 10DAYS

Due to (or as a consequence of):
b. CONGESTIVE HEART FAILURE — 10DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mamatha S Ananth PGY3 RESIDENT
29c. License number: PO 8417
29d. Date signed *(Month, Day, Year)*: Oct 14 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAMATHA S. ANANTH ST AGNES HOSPITAL 900 CATONAGE BALTIMORE MD 21229

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

NAME: ARNOLD DORIS H

97 31463

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nathaniel Alston
2. DATE OF DEATH (Month, Day, Year): 10 17 97
3. TIME OF DEATH: 5:05 AM
4. SOCIAL SECURITY NUMBER: 219-16-7974
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 31, 1922
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Bayview Medical
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: n/a

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Edgmere
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7228 Orth Rd.
10f. ZIP CODE: 21219
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel Worker
16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel
17. FATHER'S NAME (First, Middle, Last): William Alston
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eunice Hayles
19a. INFORMANT'S NAME (Type/Print): Essie Alston/wife
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7228 Orth Rd. Balto., MD 21219
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest VA — DATE: 10/22
20c. LOCATION — City or Town, State: Owings Mills, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons Funeral Home, 1701 Laurens St. Balto., MD 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	<4 hrs
DUE TO (OR AS A CONSEQUENCE OF): b.	Cardio Pulmonary arrest	9/12/97
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Sleep Apnea	years
DUE TO (OR AS A CONSEQUENCE OF): d.	ASCVD → dilated Cardiomyopathy	x years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation, HTN, CVA x2

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES [ ] NO [ ] UNCERTAIN [ ]

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: WR MD
29c. LICENSE NUMBER: D043 83
29d. DATE SIGNED (Month, Day, Year): 10/17/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W. B. Greenough MD — Johns Hopkins Geriatrics Center, 5505 Hopkins Bayview Circle
31. DATE FILED (Month, Day, Year): OCT 20 1997
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31464

- Item1 10-20-97 FilmG752 W.H. Per Doctor

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Qamar Syeda Alam (Syeda Qamar ~~Alam~~)

2. Data of Death: Month: October Day: 19 Year: 1997

3. Time of Death: 22:15p

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: na

Funeral Director

5. Social Security Number: 219-49-2973

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): APRIL30,1933

9. Birthplaca (State or Foreign Country): HYDERBAD, INDIA

Usual Residence of Dacedant

10a. State: MD

10b. County: n.a

10c. City, Town or Location: BELAIR

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Numbar: 1005 REDPUMP ROAD

10f. Zip Code: 21014

10g. Citizen of Whet Country?: HYDERABAD, INDIA

11. Marital Status: 1☐Navar Married 2☒Married 3☐Widowad 4☐Divorced

12. Wes Decedant Evar in U.S. Armad Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☒Yas 2☐No Specify: INDIAN (Hyderabad)

14. Raca - Amarican Indian, Black, White, atc. Specify: ASIAN

15. Decedant's Education (Specify only highest grede completed)
Elementery/Secondery (0-12): 5 th
College (1-4or 5+): -

16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): HOUSEWIFE

16b. Kind of Business/Industry: DOMESTIC

17. Father's Nama (First, Middle, Last): SYED HUSSAIN SHEZA

18. Mother's Nema (First, Middle, Meiden Surneme): FATIMA SHEZA

19a. Informant's Nema/Ralationship (Type, Print): MANZOOR ALAM I M.A.KHAN

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1410 CYPRESS ST, apt.16, BELAIR,MD21014

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): FAMILY PLOT

Data: Ship

20c. Location - City or Town, Stata: HYDERABAD, INDIA

21. Signature of Funaral Sarvica Licansee: Gabrielle Cook

22. Nama and Address of Facility: WM. C. MARCH FH.-4300 WABASH AVENUE #15 BALTIMORE, MD, USA

Physician /Medical Examiner

23a. Part1. Enlar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only ona causa on aach line.

		Approximate Interval Between Onsat and Death
Immadiata Causa (Final disaese or condition resulting in death) a.	aspiration of gastric contents	3 hours
Dua to (or as a consequanca of): b.	bowel obstruction	4 days
Sequantially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Diseasa or Injury that initiated avants resulting in deeth) Last c.	metastatic gallbladder cancer	2 months
Dua to (or as a consequanca of): d.		

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Ware autopsy findings available prior to complation of causa of death? 1☐Yas 2☒No

25. Was casa rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Hema 5☐Rasidanca 6☐Othar (Specify)

27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and dua to tha causa(s) and manner as stated. 2☐Medical Examiner: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, dete end piece, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: MD

29c. Licansa number: RES-000

29d. Data signad (Month, Day, Year): October 19, 1997

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print): Dorry Seven, 17 Charles Plaza, Baltimore, MD 21201

State Registrar

31. Data filed (Month, Day, Yeer): OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

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To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31465

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIAN ATKINSON
2. Dete of Deeth — Month: October Day: 18 Yeer: 1997
3. Time of Deeth: 10 30 AM
4e. Fecility Neme *(If not institution, give street end number)*: Loch RAVEN NURSING Home
4b. City, Town, or Location of Death: Loch Raven
4c. County of Deeth: BALTimore
5. Sociel Security Number: 220-05-3929
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. lest birthdey)*: 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: JANUARY 4, 1913
9. Birthplece *(Stete or Foreign Country)*: MaryLAND

Funeral Director

Usuel Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTimore, CiTY
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street end Number: 3304 ORLANDO AVE
10f. Zip Code: 21234
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grede completed)* — Elemantary/Secondary (0-12): 12th — College (1-4or 5+): N/A
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK
16b. Kind of Business/Industry: CITY
17. Fether's Name *(First, Middle, Last)*: GEORGE. W. WILLIAMS
18. Mother's Name *(First, Middle, Maiden Surname)*: HeLeN
19e. Informent's Neme/Relationship *(Type, Print)*: MR THOMAS STEVENS
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1316 W. 41ST BALTIMORE, MD 21211
20a. Mathod of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: PARKWOOD CEMETERY
Dete: 10/21/97
20c. Location - City or Town, State: BALTimore, MD.
21. Signature of Funerel Service Licensee: ▶ Hartley Miller
22. Neme end Address of Facility: Hartley Miller, Funeral Home 7527 Harford. RD. BALTIMORE, MD 21234

Physician /Medical Examiner

23a. Part I. Enter the diseese, or comptications thet caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feiture. List only one cause on eech line. — Approximete Intervel Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death)
e. ARTERIOSCOLORIC cardio Vascular

Due to (or es e consequence of):
Disease

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
CHRONIC OBSTRUCTIVE Pulmonary Disease
Acute Bronchitis
OLD CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was casa referred to medical exeminar? 1☐ Yes 2☑ No
26. Plece of Deeth *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Deeth: 1☑ Neturet 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Deta of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred et the time, data end place, and due to the cause(s) end menner stated.
29b. Signeture end title of certifier: ▶ FAUSTO Q. AQUINO MD
29c. License number: D14697
29d. Dete signed *(Month, Day, Yeer)*: OCT, 18, 1997
30. Nama and eddress of parson who completed cause of death (Item 23e) (Type, Print): FAUSTO Q. AQUINO JR MD 8713 Harford RD Balti MD 21234

State Registrar

31. Dete filed *(Month, Day, Yeer)*: OCT 20 1997
32. Regi[illegible]'s Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permet. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31466

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RONALD HARRISON BAUER
2. Date of Death (Month, Day, Year): OCTOBER 14, 1997
3. Time of Death: 8 PM
4a. Facility Name *(If not institution, give street and number)*: 1906 OAKLEY RD.
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 214-56-0927
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JULY 21, 1950
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1906 OAKLEY RD.
10f. Zip Code: 21061
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: VIET NAM
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALESMAN
16b. Kind of Business/Industry: AUTOMOTIVE

17. Father's Name *(First, Middle, Last)*: JOHN A. BAUER, 3RD
18. Mother's Name *(First, Middle, Maiden Surname)*: THELMA JUNE POSEY

19a. Informant's Name/Relationship *(Type, Print)*: BARBARA CHAVEZ / EX-WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 71 MEADOW RD., PASADENA, MARYLAND 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOUNT VIEW CEMETERY — Date: OCTOBER 17,1997
20c. Location - City or Town, State: MARRIOTTSVILLE, MD

21. Signature of Funeral Service Licensee ▶ [signature]
22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Small Cell Cancer of Lung — 10 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] MD
29c. License number: D18587
29d. Date signed *(Month, Day, Year)*: Oct 15 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL GORMUSY 900 CATON AVE BALTO MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997
32. Registrar's Signature ▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31467

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Lest): WALTER BURNHAM
2. Dete of Deeth: Month 10 Dey 14 Yeer 1997
3. Time of Deeth: 4.50PM
4e. Feciity Name (If not institution, give street and number): CHURCH HOSP CORP
4b. City, Town, or Location of Death: BALTO
4c. County of Deeth: BALTIMORE CITY

Funeral Director

5. Socie! Security Number: 213-10-5035
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthdey): 97 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Dete of Birth (Month, Dey, Yeer): APR. 16, 1900
9. Birthplace (Stete or Foreign Country): VIRGINIA

Usuei Residence of Decedent

10e. Stete: MARYLAND
10b. County: BALTIMORE CITY
10c. City, Town or Locetion: BALTIMORE
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street end Number: 2818 OVERLAND AVE.
10f. Zip Code: 21214
10g. Citizen of Whet Country?: UNITED STATES
11. Maritei Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Rece - American Indien, Bieck, White, etc.: Specify: WHITE
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 6; College (1-4or 5+):
16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired): GROCER
16b. Kind of Business/Industry: SELF EMPLOYED GROCER
17. Fether's Neme (First, Middle, Last): JOSHUA THOMAS BURNHAM
18. Mother's Name (First, Middle, Meiden Surneme): CHRISTINA GERTRUDE MANGER
19a. Informant's Name/Relationship (Type, Print): CAROL F. KEMP/ DAUGHTER
19b. Mailing Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code): 1791 REGENTS PARK RD., CROFTON, MARYLAND 21114
20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): METRO CREMATORY, INC.
Dete: OCT. 15 1997
20c. Location - City or Town, Stete: CATONSVILLE, MARYLAND
21. Signeture of Funerel Service licensee: [signature]
22. Neme end Address of Feciity: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, euch es cardiec or respiretory errest, shock, or heert feiiure. List only one cause on eech line. (Approximete Interval Between Onset and Deeth)

Immediate Cause (Finei diseese or condition resulting in deeth): e. ACUTE RENAL FAILURE
Due to (or es e consequence of): b. CARCINOMA PANCREAS.
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest: Due to (or es e consequence of): c.
Due to (or es e consequence of): d.

Pert il. **Other aignificant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: CARCINOMA BLADDER ; OBSTRUCTIVE JAUNDICE , CORONARY ARTERY DISEASE

23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
24e. Wes en eutopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1 ☐ Yes 2 ☑ No
25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Piece of Deeth (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Menner of Deeth: 1 ☑ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28e. Date of Injury (Month, Dey Yeer): NO INJURY
28b. Time of Injury: M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Deecribe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)
29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. 2 ☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner stated.
29b. Signeture end title of certifier: [signature]
29c. License number: D18977
29d. Date signed (Month, Dey, Yeer): 10/14/1997
30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 100 N BROADWAY; BALTO, MD 21231

State Registrar

31. Dete filed (Month, Dey, Yeer): 10/14/1997
32. Registrer's Signeture: OCT 20 1997 Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

NAME KNOWN TO PHYSICIAN

Baltimore, Maryland 21215-0020

Send VITAL RECORDS to the PHYSICIAN in charge of the case. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31468

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Elizabeth Brown
2. Date of Death Month / Day / Year: Oct. 17, 1997
3. Time of Death: 10 pm
4a. Facility Name *(If not institution, give street and number)*: Genesis ElderCare
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 213-03-3492
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 21, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13 E. Cherry Hill Rd.
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plant Worker
16b. Kind of Business/Industry: Ice Cream

17. Father's Name *(First, Middle, Last)*: Albert Franklin Brown
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Josephine Dennis

19a. Informant's Name/Relationship *(Type, Print)*: Albert F. Brown, Jr.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9951 Oaklea Ct., Ellicott City, Md. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Druid Ridge Cem. Date: Oct. 20, 1997
20c. Location - City or Town, State: Pikesville, Md.

21. Signature of Funeral Service Licensee: H.J. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LIVER CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD
29c. License number: D38708
29d. Date signed *(Month, Day, Year)*: 10/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHERLEY M. CABBELL, MD 4000 Old Court Rd, Baltimore, MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997
32. Registrar's Signature: Judith Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31469

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary E. Bennington

2. Date of Death Month Day Year: October 17 1997

3. Time of Death: 2:15 PM

4a. Facility Name (If not institution, give street and number): 6909 Fait Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-40-0288

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 28 1942

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 6909 Fait Ave.

10f. Zip Code: 21224

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Medical Aid

16b. Kind of Business/Industry: Nursing Home

17. Father's Neme (First, Middle, Last): William Smith

18. Mother's Name (First, Middle, Maiden Surneme): Ethal Craig

19a. Informant's Neme/Relationship (Type, Print): Deborah Markey / daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6909 Fait Ave. Baltimore, Md 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn Cemetery

Date: 10-22-97

20c. Location - City or Town, State: Baltimore, Md

21. Signeture of Funeral Service Licensee: Anthony Colt Connelly

22. Name and Address of Facility: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Perf1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Renal Cell Carcinoma — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner steted.

29b. Signature and titie of certifier: Will Sharfman

29c. License number: 038409

29d. Dete signed (Month, Day, Year): 10/20/97

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): William Sharfman M.D. 4940 Eastern Blvd. Baltimore, Md 21224

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31470

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kenneth R. Blazer
2. Date of Death (Month, Day, Year): October 18, 1997
3. Time of Death: 8:32 AM
4a. Facility Name (If not Institution, give street and number): Va Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 178-24-5165
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 14, 1920
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9318 Dubarry Avenue
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Equipment Repairman
16b. Kind of Business/Industry: Telephone

17. Father's Name (First, Middle, Last): Francis C. Blazer
18. Mother's Name (First, Middle, Maiden Surname): Anna E. Rush

19a. Informant's Name/Relationship (Type, Print): Minnie E. Blazer : Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9318 Dubarry Avenue Lanham, Maryland 20706

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Birch Hill Cemetery
Date: 10/21
20c. Location - City or Town, State: Burnham, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ Michael P. Marzullo
22. Name and Address of Facility: Marzullo Funeral Service, 3981 Carrollton Road Upperco, Maryland 21155

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Coronary artery disease — 25 min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sidorov MD
29c. License number: 40859 4
29d. Date signed (Month, Day, Year): 10/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Vladimir B. Sidorov M.D.

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
32. Registrar's Signature: ▶ Julia Davidson-Randolph

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

97 31471

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ITLEAN COOK
2. DATE OF DEATH (Month, Day, Year): October 13 1997
3. TIME OF DEATH: 1020 PM
4. SOCIAL SECURITY NUMBER: 219-03-6874
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 9, 1916
8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Geriatric Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: N/A

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1030 S. Hanover Street
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY: OWN Home
17. FATHER'S NAME (First, Middle, Last): Gilbert Felder
18. MOTHER'S NAME (First, Middle, Maiden Surname): Callie Ballard
19a. INFORMANT'S NAME (Type/Print): Isaac Felder
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 S. Catherine Street Baltimore, Maryland 21223
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Calvary Cemetery — DATE: 10-17-97
20c. LOCATION — City or Town, State: Glen Burnie, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sharron D. Boykins
22. NAME AND ADDRESS OF FACILITY: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO, MD. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CVA	1 MONTH
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	HYPERTENSION	20 YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
c.	TYPE 2 DIABETES MELLITUS	15 YEARS
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael A. Ankrom MD
29c. LICENSE NUMBER: D46360
29d. DATE SIGNED (Month, Day, Year): ▶ OCTOBER 14, 1997
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL A. ANKROM 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224
31. DATE FILED (Month, Day, Year): OCT 20 1997
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31472

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: RILEY ROGERS CREDLE SR.

2. Dete of Deeth (Month, Day, Yeer): OCTOBER 5,1997

3. Time of Deeth: 0920 AM

4e. Facility Neme *(If not institution, give street end number)*: SAINT JOSEPH HOSPITAL CENTER

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Numbar: 243-50-3749

6. Sex: 1☒ 2☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: FEB.9,1938

9. Birthplace *(State or Foreign Country)*: SWANQUARTER NC

Usuel Residence of Decedent

10e. Stete: MD

10b. County: na

10c. City, Town or Locetion: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 3425 ESSEX ROAD

10f. Zip Code: 21207

10g. Citizen of Whet Country?: UNITED STATES

11. Marital Status: 1☐ Never Married ☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐ Yes ☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Educetion *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12 th | College (1-4or 5+): -

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: HORN & HORN WHITE COFFEE POT

17. Father's Nema *(First, Middle, Last)*: ANDREW CREDLE

18. Mother's Neme *(First, Middle, Maidan Surname)*: BEATRICE WHITAKER

19e. Informent's Neme/Reletionship *(Type, Print)*: HURLIE CREDLE- WIFE

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3425 ESSEX ROAD, BALTIMORE,MD 21207

20a. Method of Disposition: ☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: WOODLAWN CEMETERY

Date: 10-11-97

20c. Location - City or Town, Stete: BALTIMORE co,MD

21. Signature of Funerel Service Licensee: Jerome A. Thompson

22. Name and Address of Feciility: WM. C. MARCH FH.-4300 WABASH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in deeth)

a. SUDDEN CARDIAC ARREST

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated evants resulting in deeth) Last

b. CORONARY ARTERY DIDEASE

Due to (or es e consequence of):

c. DIABETES MELLITUS

Due to (or es e consequence of):

d.

Part II. **Other signficant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.: HYPERCHOLESTEROLEMIA

23b. Did tobacco use contribute to the cause of death? ☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes ☒ No

24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 1☐ Yes ☒ No

25. Wes cese referred to medical exeminar? 1☐ Yes ☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient ☒ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: ☒ 1 Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medicat Examiner:** On the basis of exemination end/or investigation, In my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner steted.

29b. Signetura and title of certifier: Charles Moore MD

29c. License number: D35330

29d. Dete signed *(Month, Dey, Yeer)*: OCTOBER 7, 1997

30. Neme end eddress of person who completed cause of deeth (Item 29a) (Type, Print): CHARLES MOORE ,M.D. 5311 OLD COURT ROAD, BALTIMORE,MD 21133

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: OCT 20 1997

32. Registrer's Signeture: Julia Davidson-Randolph CO

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Print. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31473

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clayton Caster

2. Deta of Deaath — Month: October Day: 18 Year: 1997

3. Tima of Deeth: 4:33 AM

4e. Facility Nama (If not institution, giva streat and number): Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Sociel Sacurity Numbar: 206-09-1204

6. Sax: 1☒ M 2☐ F

7. Aga (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Feb. 28, 1918

9. Birthplace (State or Foreign Country): Ohio

Usual Rasidanca of Decedant

10a. Stata: Maryland

10b. County: Baltimore

10c. City, Town or Location: Pikesville

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 8 Stonehenge Circle, Unit 5

10f. Zip Code: 21208

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Giva Yaar or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexican, Puerto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Rece - American Indian, Black, Whita, atc. Specify: White

15. Decedant's Education (Specify only highast grada completed): Elamantary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Clerical Clerk

16b. Kind of Businass/Industry: Social Security Admin. Federal Government

17. Fathar's Neme (First, Middla, Last): Clayton Jacob Caster, Sr.

18. Mothar's Name (First, Middla, Maidan Surnama): Jennie May McElhaney

19a. Informant's Name/Relationship (Type, Print): Charles C. Caster

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): P.O. Box 145, Hanover, MD 21076

20a. Mathod of Disposition: 1☐ Burial 2☒ Crametion 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Piece of Disposition (Nama of camatary, crematory or other piece): Metro Crematory, Inc.

Data: October 20, 1997

20c. Location - City or Town, State: Catonsville, Maryland

21. Signatura of Funaral Service Licensee: Kirkley-Ruddick

22. Nama and Address of Facility: Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or haart feilura. List only ona causa on aach lina.

Approximeta Intarval Batween Onset end Death

Immediate Cause (Final disaasa or condition rasulting in daath)

a. Acute Myocardial Infarction — 17 hours

Dua to (or as a consequanca of):

b. Coronary Artery Disease — years

Sequantially list conditions, if eny, leading to immadiate cause. Entar Underlying Causa (Disaase or Injury that initiatad avents rasulting in daath) Last

Due to (or as a consequence of):

c. Hypertension — years

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Colon Cancer

Gastro Esophageal Cancer

Prostate Cancer

23b. Did tobecco use contribute to the cause of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was casa referred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determinad

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

28e. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier (Check only one) 1☒ **Cartifying Physician:** To tha best of my knowledga, death occurrad at tha tima, date and place, end dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Resident Physician

29c. Licanse number: AS2402321-BC9021

29d. Date signad (Month, Day, Year): October 18, 1997

30. Nama and eddress of person who completed causa of death (Item 23e) (Type, Print): 2401 West Belvedere Avenue, Baltimore, Maryland, 21215

State Registrar

31. Deta filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: Gloria Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

T

5

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31474

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marion Cartwright

2. Date of Death Month: October Day: 15 Year: 1997

3. Time of Death: 3:30 PM

4a. Facility Name *(If not institution, give street and number)*: Franklin Woods Nursing Center

4b. City, Town, or Location of Death: Rossville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 190-03-1791

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 14, 1917

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1714 Langley Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Barclay H. Bottenhorn

18. Mother's Name *(First, Middle, Maiden Surname)*: Twila Greeley

19a. Informant's Name/Relationship *(Type, Print)*: Orten James Cartwright (SON)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 36 Terron Ct. Baltimore , Md. 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hazelet Cemetery | Date: 10/18/1997

20c. Location - City or Town, State: Cherry Tree, PA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Alzheimers disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. failure to thrive

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Malapati MD

29c. License number: D050757

29d. Date signed *(Month, Day, Year)*: October 16, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 9105 Franklin Square Drive. Baltimore. MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31475

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEAN DYER
2. Date of Death Month Day Year: OCTOBER 1, 1997
3. Time of Death: 6:40PM
4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL
4b. City, Town, or Location of Death: OLNEY
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 232-26-9024
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG22,1917
9. Birthplace (State or Foreign Country): W.VIRGINIA

Usual Residence of Decedent

10a. State: MD.
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3752 S.LEISURE WORLD BLVD
10f. Zip Code: 20910
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 2YEARS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINSTRATIVE ASST.
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): F. BRENT BARTLETT
18. Mother's Name (First, Middle, Maiden Surname): PAULINE JESSIE SILLERY

19a. Informant's Name/Relationship (Type, Print): PETER WHITE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13309 KEATING ST. ROCKVILLE, MD.20853

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GEORGETOWN MED. SCH. Date: 10/1/97
20c. Location - City or Town, State: WASAINGTON,DC.

21. Signature of Funeral Service Licensee: Larry A. Austin
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH,DC.20011

Physician /Medical Examiner

29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	one year
Due to (or as a consequence of): b.	Abdominal surgery	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	for Metastatic Ovarian	
d.	Cancer	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitra Ramaiah M.D.
29c. License number: D42452
29d. Date signed (Month, Day, Year): OCT 24 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. CHITRA RAMAIAH GOPAL, M.D., 18111, PRINCE PHILIP DRIVE, SUITE 327, OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death, with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 31476

Reg. No.

Item:8 per FH G-753 11/14/97 dh

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Farrell Dunaway

2. Date of Death (Month, Day, Year): October 16, 1997

3. Time of Death: 8:10a.m.

4a. Facility Name *(If not institution, give street and number)*: 2326 Calverton Heights Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-12-5598

6. Sex: XX M 2☐ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 2/3/19 ~~Feb. 3, 1997~~

9. Birthplace *(State or Foreign Country)*: Va.

Usual Residence of Decedant

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: XX Yes 2☐ No

10e. Street and Number: 2326 Calverton Heights Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married XX Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas XX No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Ricen, atc.): 1☐ Yes 2☐ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Scalman

16b. Kind of Business/Industry: Charles H. Harper & Associates

17. Father's Name *(First, Middle, Last)*: Samuel Dunaway

18. Mother's Name *(First, Middle, Maiden Surname)*: Clara Curry

19a. Informent's Name/Relationship *(Type, Print)*: Cora B. Dunaway wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2326 Calverton Heights Avenue Baltimore, Md. 21216

20a. Method of Disposition: XX Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Auburn Cemetery

Data: Oct. 20

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Ernest R. Emery Jr.

22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications whet ceused the death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death) a. Lung Carcinoma — 3 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in daath) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? XX 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas XX 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was cese rafarred to medical examiner? 1☐ Yas XX 2☐ No

26. Placa of Daath *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: XX 1☐ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: XX 1☐ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as statad. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: Christie Lamburg

29c. Licanse number: D32263

29d. Data signed *(Month, Day, Year)*: 10/17/97

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): 1940 West Baltimore St Balt Md 21223

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31477

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: JOHN FRANCIS DUERR, JR.

2. Data of Daath — Month: OCT Dey: 16 Year: 97

3. Tima of Deeth: 8:36A

4a. Facility Nama *(If not institution, giva streat and numbar)*: GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Daeth: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Sacurity Numbar: 220-22-4229

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 68 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 7/1/29

9. Birthplaca *(State or Foreign Country)*: MARYLAND

Usual Residance of Dacedant

10a. Stata: MD

10b. County: BALTIMORE

10c. City, Town or Location: HILLENDALE

10d. Insida City Limits: 1☐ Yes 2☒ No

10e. Straet and Number: 1104 HALSTEAD ROAD

10f. Zip Coda: 21234

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☒ Yas 2☐ No — If Yas, Giva Yeer or Detes: KOREAN

13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grada complatad)*: Elamantary/Secondary (0-12): 12th GRADE — Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa ratired)*: PURCHASING AGENT

16b. Kind of Businass/Industry: ARUNDEL CORP.

17. Fathar's Nema *(First, Middla, Last)*: JOHN F. DUERR, SR.

18. Mother's Name *(First, Middla, Maidan Surnama)*: ETHEL WATERS

19a. Informant's Name/Ralationship *(Type, Print)*: MARY JEAN DUERR WIFE

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1104 HALSTEAD ROAD BALTIMORE, MD 21234

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or other place)*: MORELAND MEMORIAL PARK

Data: 10/20/97

20c. Location - City or Town, Stata: HILLENDALE, MD

21. Signatura of Funaral Service Licansad ▶

22. Nama and Address of Facility: JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, shock, or hean failura. List only one ceuse on eech lina.

Approximata Intarval Batwaen Onsat and Deeth

Immediete Ceuse (Finel disaase or condition rasulting in deeth): e. ANOXIC ENCEPHALOPATHY

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated avants resulting in deeth) Lest:

b. MYOCARDIAL INFARCT

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to complation of causa of deeth? 1☐ Yas 2☑ No

25. Was casa referred to medical examinar? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of *my* knowledga, daath occurred at the tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in *my* opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and *mannar* statad.

29b. Signatura and titla of cartifiar: ▶ [signature] MD

29c. Licansa number: P 11400

29d. Data signed *(Month, Day, Year)*: OCT/16/97

30. Nama and address of person who complatad causa of death (Item 23e) (Type, Print): DUA, GOOD SAMARITAN HOSPITAL, BALTIMORE, MD 21239

State Registrar

31. Data filed *(Month, Day, Year)*: OCT 20 1997

32. Registrar's Signature ▶ [signature] Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31478

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Florence Betty Essers

2. Date of Death Month Day Year: October 09, 1997

3. Time of Death: 7:30 AM

4a. Facility Name *(If not institution, give street and number)*: St. Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 218-20-0995

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 06,1927

9. Birthplace *(State or Foreign Country)*: New York,NewYork

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6902 Petworth Road

10f. Zip Code: 21212-1942

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: Education/ Baltimore Co. Schools

17. Father's Name *(First, Middle, Last)*: William M. Hager

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Kopp

19a. Informant's Name/Relationship *(Type, Print)*: Mr. Hendrik A. Essers (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6902 Petworth Rd. Baltimore, Md. 21212-1942

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gard.

Date: 10/13/97

20c. Location - City or Town, State: Timonium, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md.21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CARDIAC ARRYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MITRAL VALVE DISEASE

CORONARY ARTERY DISEASE

CARDIO MYOPATHY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: M.D.

29c. License number: 34366

29d. Date signed *(Month, Day, Year)*: 10/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL A GURBEL 200 E. 33rd ST. SUITE 501 BALTO, MD. 21218

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997

32. Registrar's Signature: Erika Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

97-5966-005
wlc
LEONARD JOSEPH
ECK

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leonard Joseph Eck
2. Data of Death Month, Day, Year: October 16, 1997
3. Time of Death: 300p
4a. Facility Name (If not institution, give street and number): 501 SCHOTTS ROAD
4b. City, Town, or Location of Death: ESSEX
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-14-0514
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Yaar: Months / Days | If Undar 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Yeer): Nov. 29, 1922
9. Birthplaca (Stata or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 501 Schotts Lane
10f. Zip Code: 21221
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Naver Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Yaar or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lynotype Operator
16b. Kind of Business/Industry: Magazine Printing

17. Father's Name (First, Middle, Last): Lawrence Eck
18. Mother's Nama (First, Middle, Maiden Surname): Catherine Slovek

19a. Informant's Name/Relationship (Type, Print): Donn Eck (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8621 Heathermill Road Baltimore, Maryland 21236

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Spacify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Crematory
Date: 10/18/1997
20c. Locetion - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Donna F. Bruzdzynski
22. Name and Address of Facility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deaih) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? Inspection 1 [ ] Yes 2 [XX] No
24b. Were eutopsy findings available prior to completion ot cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [XX] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [XX] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be datarminad
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Numbar, City or Town, Stete)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2 [XX] **Medicat Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Stephen S. Radentz, MD
29c. Licensa number: O.C.M.E.
29d. Data signed (Month, Day, Year): October 17, 1997
30. Neme and address of person who completed cause ot deeth (Item 23e) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
32. Registrar's Signature: Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

RC
10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31480

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Jacob Finazzo Jr.

2. Date of Deeth — Month: October Dey: 13 Yaar: 1997

3. Time of Death: 1315

4a. Facility Neme (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-52-2211

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 48 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 17 1949

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Dacedent

10a. Stete: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 518 Scott St.

10f. Zip Code: 21230

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 9 — College (1-4or 5+):

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Businass/Industry: Soft Drink

17. Fether's Nama (First, Middle, Last): Jacob J. Finazzo Sr.

18. Mother's Name (First, Middle, Maiden Surneme): Ruth Flannigan Finazzo

19a. Informant's Name/Reletionship (Type, Print): Anthony Finazzo / Brother

19b. Meiling Addrass (Street end Numbar or Rural Route Number, City or Town, Stata, Zip Code): 1025 Maiden Choice Lane Baltimore Md.21229

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetary, cremetory or other piece): Metro Crematory

Dete: 10/17

20c. Locetion - City or Town, Stete: Catonsville Maryland

21. Signeture of Funeral Service Licensee: [signature]

22. Neme end Address of Feclity: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus 21227

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Final diseese or condition resulting in daath)

e. SEPTIC SHOCK — 6 DAYS

Due to (or es e consequenca of):

b. GROUP A BETA HEMOLYTIC STREP. SEPSIS — 6 DAYS

Sequantielly list conditions, if any, leading to immediete causa. Enter Underlying Ceuse (Disaase or injury thet initieted evants resulting in death) Lest

Due to (or es e consequence of):

c. INTRAVENOUS DRUG ABUSE — = YEARS

Due to (or es e consequence of):

d.

Part II. **Other elgnificant conditione** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

HEPATIC FAILURE

CVA

23b. Did tobacco use contribute to the cause of desth? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of daeth? 1☐ Yes 2☒ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Mennar of Daath: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): NA

28b. Time of Injury: NA M

28c. Injury et Work? 1☐ Yes 2☐ No: NA

28d. Describe how injury occurred: NA

28e. Plece of Injury - At homa, farm, street, factory, offica building, etc. (Specify): NA

28f. Location (Street end Number or Rural Route Number, City or Town, Stete): NA

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the bast of my knowledga, daath occurred et the time, date end piece, and due to the ceusa(s) and msnner ss steted. 2☐ **Medical Examiner:** On tha basis of exemination end/or investigetion, in my opinion, daath occurred et the time, deta and place, snd due to tha cause(s) end manner statad.

Medical Certification: To Be Completed by Physician/Medical Examiner

29b. Signeture end title of certifier: ▶ Alonso, MD

29c. License number: P10871

29d. Date signed (Month, Dey, Year): OCT, 13, 1997

30. Nama end eddress of person who complated causa of death (Item 23a) (Type, Print): PILAR C. ALONSO 900 CATON AVE. BALTIMORE, MD. 21229

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

NAME: FINAZZO, JACK

2

REG

DHMH 16 Rev 6/95

97-6013-510
B.K.S

ROBERT J. FREEMAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT J. FREEMAN
2. Date of Death: Month OCT. Day 18, Year 1997
3. Time of Death: 0850 AM
4a. Facility Name (If not institution, give street and number): 1822 WEST LEXINGTON STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-42-9275
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 16, 1942
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1822 W. Lexington Street
10f. Zip Code: 21223
10g. Citizen of What Country? USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Mary R. Freeman

19a. Interment's Name/Relationship (Type, Print): Dorothea Janette Freeman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1108 N. Augusta Avenue, Baltimore, Maryland 21229
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Zion Cemetery
Date: 10/24/97
20c. Location - City or Town, State: Lansdowne, Maryland
21. Signature of Funeral Service Licensee: Sharron D. Boykins
22. Name and Address of Facility: Joseph H. Brown Jr. Funeral Home, PA. 2140 N. Fulton Avenue, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? XX [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home XX [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. M. DIXON
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): OCT. 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
For Registrar's Signature: John Gardner-Kendall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31482

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eric Ford

2. Date of Death — Month: October Day: 13 Year: 1997

3. Time of Death: 5:30 AM

4a. Facility Name (If not Institution, give street and number): 4th fl - Church NSg Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-56-9852

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-25-09

9. Birthplace (State or Foreign Country): JAMAICA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 208 N. WOLFE STREET

10f. Zip Code: 21231

10g. Citizen of What Country? USA,

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondery (0-12): 6TH GRADE — College (1-4or 5+):

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): JANITOR

16b. Kind of Business/Industry: MANUFACTURING CO.

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): DELILAH SKINNER (FRIEND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 N. CHAPEL STREET, BALTIMORE, MD. 21231

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MT ZION CEMETERY — Date: 10-17-97

20c. Location - City or Town, State: LANDSDOWNE, MD.

21. Signature of Funeral Service Licensee: Sharron D. Boykins

22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Urosepsis — Due to (or as a consequence of): — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Hypokyroidism, Hypertension

23b. **Did tobacco use contributa to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D40525

29d. Date signed (Month, Dey, Year): 10/13/97

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Rudolf Titaja, M.D. Church Hospital, BALTIMORE, MD. 21231

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31483

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtle N. Frantz
2. Date of Death Month Day Year: OCT 16, 1997
3. Time of Death: 8:50 P.M.
4a. Facility Name (If not institution, give street and number): 79 Arverne Court
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-86-9705
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Feb. 6, 1917
9. Birthplace (State or Foreign Country): Balto. Md.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 79 Arverne Court
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles W. Fowble
18. Mother's Name (First, Middle, Maiden Surname): Lena L. Lee

19a. Informant's Name/Relationship (Type, Print): Mrs. Nadine L. Miller (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 79 Arverne Court Timonium, Md. 21093

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Date: 10/20/97
20c. Location - City or Town, State: Pikesville, Md.

21. Signature of Funeral Service Licensee: Lamb B Eline
22. Name and Address of Facility: ELINE FUNERAL HOME 11824 Reisterstown Road Reisterstown, Md.21136

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Lung cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D33165
29d. Date signed (Month, Day, Year): 10/18/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven Strafer 2111 Hanover Pike Hampstead md 21074

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31484

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cassandra H. Folkert
2. Date of Death Month Day Year: Oct. 19, 1997
3. Time of Death: 10:30 p.m.
4a. Facility Name (If not institution, give street and number): 107 Lamport Rd.
4b. City, Town, or Location of Death: Reisterstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-32-4422
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 26, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Balto.
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 107 Lamport Rd.
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): Harry Hauf
18. Mother's Name (First, Middle, Maiden Surname): Lillian Quackenbusch

19a. Interment's Name/Relationship (Type, Print): John F. Folkert
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Lamport Rd., Reisterstown, Md. 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Evergreen Mem. Gardens
Date: Oct. 22, 1997
20c. Location - City or Town, State: Finksburg, Md.

21. Signature of Funeral Service Licensee: ▶ H. J. Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Coronary Vascular Dise — 5yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robt J. Moss, MD
29c. License number: D32882
29d. Date signed (Month, Day, Year): 10/20/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert C. Moss 114 Business Center Dr. Reisterstown, MD 21136

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31485

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANGELA L. FLETCHER
2. Date of Death Month Day Year: September 30, 1997
3. Time of Death: 2:45pm
4a. Facility Name *(If not institution, give street and number)*: Doctors Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-76-8811
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 41 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept.11,1956
9. Birthplace *(State or Foreign Country)*: Wash.D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7300 Powhatan Street
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Proof Operator
16b. Kind of Business/Industry: Bank

17. Father's Name *(First, Middle, Last)*: Henry McCoy
18. Mother's Name *(First, Middle, Maiden Surname)*: Bernice Edwards

19a. Informant's Name/Relationship *(Type, Print)*: LaNitra McConnell Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7300 Powhatan St. Lanham,Md. 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Mem.Park
Date: 10/7
20c. Location - City or Town, State: Landover,Md.

21. Signature of Funeral Service Licensee: ▶ F. Bernard Hunt
22. Name and Address of Facility: Hunt Funeral Home 1420 34th St.S.E.Wash.D.C.20020

To Be Completed by Funeral Director

Angela Lawanda Fletcher

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. INTRACEREBRAL HEMORRHAGE — 10 DAYS

Due to (or as a consequence of):
b. ACCELERATED HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K Mathew MD
29c. License number: D14799
29d. Date signed *(Month, Day, Year)*: 10/1/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. JOSEPH MATHEW.
6510 KENILWORTH AVE. RIVERDALE MD 20737

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31486

Items:24a,29c,30 per MD G-752 10/20/97 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLAINE DALE GREIG SR.

2. Date of Death Month Day Year: Sept. 30, 1997

3. Time of Death: 7:15 PM

4a. Facility Name *(If not institution, give street and number)*: 311 Bynum Ridge Road

4b. City, Town, or Location of Death: Forest Hill

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 206-26-3062

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 13, 1934

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residance of Dacedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 311 Bynum Ridge Road

10f. Zip Coda: 21050

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decadant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Ricen, etc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Dacedant's Education *(Specify only highast grade completad)*: Elemantary/Secondery (0-12): 12th grade; Collaga (1-4or 5+):

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: President & Owner

16b. Kind of Businass/Industry: Masonry Business

17. Fathar's Nama *(First, Middla, Last)*: Leonard C. Greig

18. Mothar's Name *(First, Middla, Maidan Surnama)*: Margaret Sipple

19a. Informant's Name/Raletionship *(Type, Print)*: Mary A. Greig (Wife)

19b. Mailing Address *(Street end Number or Rural Route Numbar, City or Town, State, Zip Code)*: 311 Bynum Ridge Road, Forest Hill, MD. 21050

20a. Mathod of Disposition: 1 [X] Buriei 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar placa)*: Bel Air Memorial Gardens

Data: 10/3/97

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Faciity: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batween Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Metastatic Colon Cancer

Due to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availabia prior to complation of causa of death? 1 [ ] Yes 2 [ ] No

25. Was cesa rafarred to medical examinar? 1 [ ] Yas 2 [ ] No

28. Place of Daath *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatiant 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Manner of Deeth: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*

28f. Location *(Straet end Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [ ] **Certifying Physician:** To tha bast of my knowledga, daath occurred at the time, data end place, and dua to tha ceusa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daath occurred at the time, data and piece, and due to the ceusa(s) and mannar stated.

29b. Signature and title of certifier: [signature] Craig M. Shaughnessy MD

29c. License number: D37078

29d. Date signed *(Month, Day, Year)*: 10/1/97

30. Neme end eddress of parsan who completed cause of death (Item 23e) (Type, Print): Dr. Craig M. Shaughnessy-104 Plumtree Road-Bel Air 21014

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:24a per MD G-752 10/20/97 dh

Certificate of Death

Reg. No. 97 31487

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ISABEL W GRIM

2. Date of Death Month: OCTOBER Day: 11 Year: 1997

3. Time of Death: 1220 HRS

4a. Facility Name (If not institution, give street and number): SAINT AGNES NURSING AND REHAB. CENTER

4b. City, Town, or Location of Death: ELLICOTT CITY

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 218-30-7401

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 5, 1909

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: HOWARD

10c. City, Town or Location: ELLICOTT CITY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: ST. AGNES NURSING & REHAB. 3000 NORTH RIDGE ROAD

10f. Zip Code: 21043

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NURSE

16b. Kind of Business/Industry: HEALTH CARE

17. Father's Name (First, Middle, Last): ALEXANDER C. WILLSON

18. Mother's Name (First, Middle, Maiden Surname): GERTRUDE HADAWAY

19a. Informant's Name/Relationship (Type, Print): CHARLES GRIM, SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9362 TILLER DRIVE, ELLICOTT CITY, MARYLAND 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY

Date: 10/15/97

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Wanda L Lemmer

22. Name and Address of Facility: WITZKE FUNERAL HOMES, INC. 1630 EDMONDSON AVE., CATONSVILLE, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Parkinsons disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Laurence R. Gallagher, MD

29c. License number: D 0 1786

29d. Date signed (Month, Day, Year): OCTOBER 13, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LAURENCE R. GALLAGER, M.D., 716 MAIDEN CHOICE LANE, BALTO, MD 21228

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Virginia Glanzer

2. Date of Death Month Day Year: OCTOBER 14 1997

3. Time of Death: 7:33AM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-22-3771

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Febuary9 1922

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Arbutus

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 976 Circle Drive

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Rudolph

18. Mother's Name (First, Middle, Maiden Surname): Minnie Kitzig

19a. Informant's Name/Relationship (Type, Print): Raymond H. Glanzer/Husband

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 976 Circle Dr. Arbutus Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Mem. Gardens

Date: 10/16

20c. Location - City or Town, State: Marriottsville Md.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus 21227

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction — hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic renal failure, diabetes

chronic obstructive pulmonary

disease,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeannine Saunders MD

29c. License number: D33081

29d. Date signed (Month, Day, Year): October 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeannine Saunders St Agnes Healthcare 900 Caton Avenue

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: Glanzer, Mary

BB

12

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31489

Physician /Medical Examiner

1. Decadant's Name *(First, Middle, Last)*: Helen Goodman

2. Data of Death Month: Oct. Day: 14 Year: 97

3. Time of Death: 11:10 P.M.

4a. Facility Nama *(If not institution, give streat end number)*: BON SECOURS

4b. City, Town, or Location of Deeth: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Sacurity Number: 212-20-6881

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: 9-26-21

9. Birthplaca *(State or Foreign Country)*: MD

Usual Rasidanca of Dacedent

10a. Stete: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yas 2☐ No

10e. Street end Number: 523 LYNHURST STREET

10f. Zip Coda: 21229

10g. Citizan of Whet Country?: USA

11. Marital Status: 1☐ Navar Married 2☑ Married 3☐ Widowed 4☐ Divorcad

12. Wes Dacedant Evar in U.S. Armad Forces? 1☐ Yas 2☑ No If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☑ No Spacify:

14. Race - Amarican Indian, Black, White, atc. Specify: BLACK

15. Decedant's Education *(Spacify only highast grada completed)*: Elamantary/Secondary (0-12): 12TH GRADE; Collaga (1-4or 5+): 2 YRS.

18a. Decedant's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratired)*: TEACHERS AIDE

16b. Kind of Business/Industry: BALTO. CITY SCHOOLS

17. Fathar's Name *(First, Middla, Last)*: ISSAC REDDIE

18. Mother's Neme *(First, Middla, Maiden Surneme)*: MARTHA BANKS

19a. Informent's Name/Ralationship *(Type/Print)*: LIMMIE GOODMAN / HUSBAND

19b. Mailing Address *(Straat and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 523 LYNHURST ST., BALTIMORE, MD 21229

20a. Mathod of Disposition: 1☑ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cemetary, cramatory or othar placa)*: ARBUTUS CEMETERY

Data: 10/20/97

20c. Location - City or Town, State: ARBUTUS, MD

21. Signature of Funeral Service Licansee: ▶ Vaughn C. Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL' PIKE, BALTO. MD 21229

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications thet causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one ceusa on aach lina.

Approximata Intarval Batween Onset and Death

Immadieta Causa (Final diseasa or condition resulting in daath): a. Cardiac arrest

Dua to (or as a consequanca of): b. Ventricular Fibrillation

Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaasa or injury thet initiated avants rasulting in daath) Last

Dua to (or as a consequanca of): c.

Due to (or as a consequence of): d.

Part II. **Othar signficant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Were eutopsy tindings availeble prior to compiation of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarrad to medicel examiner? 1☐ Yas 2☒ No

26. Piaca of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Dey Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Streat and Number or Rurel Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, deeth occurred at tha time, data and placa, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifier: ▶ Edward Obazee MD

29c. License number: D 41430

29d. Data signad *(Month, Day, Yaar)*: Oct 16th 1997

30. Neme and addrass of person who complatad cause of death (Item 23a) (Type, Print): 821 NORTH EUTAW ST #407 BALTIMORE MD 21201

State Registrar

31. Date filed *(Month, Day, Yaar)*: OCT 20 1997

32. Registrar's Signatura: Jacqueline Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Division of Vital Records. For items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31490

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Violet G. Goodrich

2. Date of Death Month Dey Yeer: October 18, 1997

3. Time of Death: 12:10 a.m.

4e. Fecility Neme *(If not institution, give street end number)*: 6410 Old Sandy Spring Road

4b. City, Town, or Location of Deeth: Laurel

4c. County of Deeth: Prince George

Funeral Director

5. Social Security Number: 577-18-9155

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Year)*: 12-5-1915

9. Birthpiece *(Stete or Foreign Country)*: Louisianna

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 7234 Carriage Hill Drive

10f. Zip Code: 20707

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: National Institute of Health

17. Fether's Neme *(First, Middle, Last)*: Albert Goebel

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Lillian Engler

19e. Interment's Neme/Reietionship *(Type, Print)*: Mary Daniels

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 7234 Carriage Hill Dr. Laurel, MD 20707

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: Balt. Wash. Crematory

Dete: 10/18/97

20c. Location - City or Town, Stete: Laurel, MD

21. Signature of Funeral Service Licensee: R. Fleck

22. Neme end Address of Fecility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Metastatic Carcinoma of Lung

Due to (or es a consequence of):

Sequentieily list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Non Resolving Post Obstructive Pneumonia

Due to (or es e consequence of):

c. Chronic OBSTRUCTIVE LUNG DISEASE

~~Due to (or as a consequence of)~~:

d. Hypertension

Part II. **Other signficent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Alzheimer's Disease

Stress and Anxiety

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was cese referred to medicel exeminer? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred: NA

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: SRudraju MD

29c. License number: D21200

29d. Dete signed *(Month, Dey, Year)*: OCT/18/1997

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print): SRINIVAS R. UDAYA 7245 B HANOVER PARKWAY GREENBELT, MD 20770

State Registrar

31. Dete filed *(Month, Day, Yeer)*: OCT 20 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 must be printed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other possible event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31491

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AGNES LOUISE GRIMM

2. Date of Death: Month OCTOBER Day 16, Year 1997

3. Time of Death: 10:13 AM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 450-40-6628

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 23, 1911

9. Birthplace (State or Foreign Country): TEXAS

Usual Residence of Decedent

10a. State: TEXAS

10b. County: GAUDALUPE

10c. City, Town or Location: SEQUIN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: P.O. BOX 1625

10f. Zip Code: 78155

10g. Citizen of What Country? UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): OSCAR REAGAN GLASSCOCK

18. Mother's Name (First, Middle, Maiden Surname): KATHERINE MARTIN

19a. Informant's Name/Relationship (Type, Print): CAROLYN M. SCHMIDT/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 1625, SEQUIN, TEXAS 78155

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): METRO CREMATORY, INC.

Date: OCT. 17 1997

20c. Location - City or Town, State: CATONSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

To Be Completed by Funeral Director

Agnes G. Grimm
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. - MYOCARDIAL INFARCTION — 24 hrs

Due to (or as a consequence of):
b. - CARDIOGENIC SHOCK — 24 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. RESPIRATORY FAILURE — 24 hrs.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M

29c. License number: D29748

29d. Date signed (Month, Day, Year): 10/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALT. MANEJUALD MD 1307 CHALA FERRY S.E. GLENBURNIE MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: [signature] Judith Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31492

ITEM: 20a,2122 per S.A G-752 10-18-97 eoh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Boy Haggins

2. Dete of Deeth: Month 8 Dey 3 Yeer 97.

3. Time of Deeth: 8 35 Pm.

4a. Facility Nome (If not institution, give street end number): Mercy Medical Center

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death:

Funeral Director

5. Sociel Security Number: NONE

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Yeer Months / Days: 7 ; If Under 24 Hrs. Hours / Min.:

8. Dete of Birth (Month, Dey, Yeer): 8/2/97

9. Birthplece (State or Foreign Country): MARYLAND

Usuel Residence of Decedent

10e. Stete: md

10b. County:

10c. City, Town or Location: BALTIMORE City

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street end Number: 1329 MANTLE St

10f. Zip Code: 21234

10g. Citizen of Whet Country? USA

11. Merital Stetus: 1 ☐ Never Merried 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 ☐ Yes 2 X No Specify:

14. Reca - American Indien, Bleck, Whita, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 0 ; College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): INFANT

16b. Kind of Business/Industry: NONE

17. Fether's Neme (First, Middle, Last): THOMAS LEE Bowman

18. Mother's Name (First, Middle, Maiden Surneme): Yolanda Haggins

19e. Informent's Name/Relationship (Type, Print): Yolanda HAGGINS

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1329 MANTLE St. BALTO. Md.

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 X Other (Specify) IN STATE

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece):

Dete:

20c. Location - City or Town, Stete:

21. Signeture of Funerel Service Licensee: ▶ JOSEPH B. VANSANT

22. Neme end Address of Facility: STATE ANATOMY BOARD, 655 W. BALTIMORE STREET BALTIMORE, MARYLAND 21201

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth):
a. Respiratory Distress Syndrome — 28 hrs
Due to (or as a consequence of):
b. Extreme Prematurity
Due to (or as a consequence of):
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last:
c. Lepsis.
Due to (or as a consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I: Anemia, Thrombocytopenia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24e. Wes en autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 X No

26. Plece of Deeth (Check only one): Hospitel: 1 X Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 X Nature 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred:

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):

28f. Location (Street end Number or Rural Route Number, City or Town, Stete):

29e. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end mennar es steted. 2 ☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and manner stated.

29b. Signeture end Title of certifier: ▶ [illegible] Neonatology

29c. License number: D48175

29d. Dete signed (Month, Dey, Yeer): 8/3/97.

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Andres Rodriguez MD 301 St Paul St Baltimore MD.

State Registrar

31. Date filed (Month, Dey, Yeer): OCT 1 8 1997

32. Registrer's Signeture: Lisa Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

97-5967-027

KEITH HANNAN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31493

Physician /Medical Examiner | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Keith Brian Hannan

2. Date of Death: Month: october Day: 16, Year: 1997

3. Time of Death: 1:30P.M.

4a. Facility Name (If not institution, give street and number): 9112 BRYANT AVE

4b. City, Town, or Location of Death: LAUREL

4c. County of Death: HOWARD

5. Social Security Number: 297-56-4736

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 9-26-1956

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 [ ] Yes 2 [XX] No

10e. Street and Number: 9112 Bryant Avenue

10f. Zip Code: 20723

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [XX] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Technician

16b. Kind of Business/Industry: Computer

17. Father's Name (First, Middle, Last): James V. Hannan

18. Mother's Name (First, Middle, Maiden Surname): Mary Ann Witkowski

19a. Informant's Name/Relationship (Type, Print): Sharon A. Hannan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9112 Bryant Avenue Laurel, MD 20723

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Balt. Wash. Crematory

Date: 10-17-97

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Public Pages 1 and 2 shall be completed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Entraoral Shotgun Wound

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? partial 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): Found 10/16/97

28b. Time of Injury: 1230 HR M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject shot self

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 9112 Bryant Avenue Laurel Maryland

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kiger MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): OCTOBER 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KIGER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15x1

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Hammen

2. Date of Death Month, Day, Year: October 18, 1997

3. Time of Death: 4:00A

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 218-28-1850

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 18 1918

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1915 Stanhope Rd

10f. Zip Code: 21222

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Anthony Hrica

18. Mother's Neme (First, Middle, Maiden Surname): Lenora Slezak

19a. Informant's Name/Reletionship (Type, Print): Louis Hammen / son

19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 George Ave. Baltimore, Md 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus

Date: 10-22

20c. Location - City or Town, State: Baltimore, Md

21. Signeture of Funeral Service Licensee: Anthony Cdt Connelly

22. Name end Address of Facility: Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. Ischemic Bowel — 8 hrs

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest

b. Post operative replacement of thorac

Due to (or es a consequenca of):

c. Abdominal Aneurysm for Aortic embolism — 16 hrs.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Renal dysfunction

Gangrene of (L) foot.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signeture end titie of certifier: G. Williams M.D.

29c. License number: D 01769

29d. Date signed (Month, Day, Year): 10/18/97

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): G.M. Williams, 601 Harvey Johns Hopkins Hospital, Baltimore 21287

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 31495

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary M. Johnson
2. Date of Death Month Dey Year: Oct. 6, 1997
3. Time of Death: 5:25 PM
4a. Facility Name (If not institution, give street and number): Genesis Elder Care
4b. City, Town, or Location of Death: Catonsville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-30-5874
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Oct. 29, 1903
9. Birthplace (State or Foreign Country): Va.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 16 Fusting Avenue
10f. Zip Code: 21228
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic
16b. Kind of Business/Industry: Private Families

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Anna Bennett foster sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2107 Liberty Heights Avenue Baltimore, Md.21217

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Oct.17
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Herbert E. Nutter
22. Name and Address of Facility: Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Myocardial Infarction — few hours
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ M. DeChaney MD
29c. License number: D-40521
29d. Date signed (Month, Day, Year): October 15, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print): DR OCHANEY 3350 WILKENS AVENUE SUITE 302 BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year): OCT 20 1997
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31496

DORIS MINNIE JACKSON
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Doris Minnie Jackson
2. Date of Death Month: 10ct Day: 11 Year: 1997
3. Time of Deeth: 9:60PM
4a. Facility Name (If not institution, give street and number): DEATON SPECIALTY HOSPITAL 611 S. Charles Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City.

Funeral Director

5. Social Security Number: 220-22-0723
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 11, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: City
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 611 S. Charles Street
10f. Zip Code: 21230
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorcad
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Baby Sitter
16b. Kind of Business/Industry: Child Care

17. Father's Name (First, Middle, Last): Nathan Allen
18. Mother's Name (First, Middle, Maiden Surname): Ellen Washington

19a. Informent's Name/Relationship (Type, Print): Winfield Jackson III/Son
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 1000 W. Lafayette Ave. Apt 1 Balto, MD. 21217

20a. Method of Disposition: 1☑ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Allen-Washington
Date: 10/18/97
20c. Location - City or Town, State: Jessup, Maryland

21. Signature of Funeral Service Licansee: ▶ Gary P. March
22. Name and Address of Facility: Gary P. March F.H. 270 Fredhilton Pass Baltimore, MD 21229

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disease or condition resulting in death) a.	Chronic Renal Jailure.	8yeer.
Due to (or es a consequence of): b.	Nephrosclerosis.	8years.
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in death) Last — Due to (or es a consequence of): c.	Hypertension.	years.
Due to (or as a consequence of): d.	Insulin dependent diabetes mellitos.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- Peripheral vascular disease.
- Below knee amputation.

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD.
29c. License number: D44973
29d. Date signed (Month, Day, Year): Oct 12 1997.

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): GURMEET S. SAWHNEY MD, 325 HOSPITAL DRIVE 202, Glen Burnie MD21061.

State Registrar

31. Date filed (Month, Day, Year): OCT 18 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 16 Rev 6/95

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ITEM#7 PER F.H.10-21-97 J.A. FILM#G752

Item8 10-20-97 FilmG752 W.H.Per F/H

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31497

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIE M JOHNSON

2. Date of Death — Month: 10 Day: 14 Year: 97

3. Time of Death: 2205 P

4e. Facility Name *(If not institution, give street and number)*: UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE, MD

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 219-20-5479

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73-75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 3 ~~2~~/~~22~~/24 1922

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE CITY

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 3512 VENETIAN DRIVE

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th grade — College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY

16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name *(First, Middle, Last)*: Nathan Banks

18. Mother's Name *(First, Middle, Maiden Surname)*: Amanda Burell

19a. Informant's Name/Relationship *(Type, Print)*: Mary H. Jones - Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 511 Cumberland Street Balto, md 21217

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Baltimore National — Date: 10-21-97

20c. Location - City or Town, State: Baltimore, md 21228

21. Signature of Funeral Service Licensee: Gabrielle Cuny

22. Name and Address of Facility: March F.H. West 4300 Wabash Avenue Balto, md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HEART DISEASE — 20 years

Due to (or as a consequence of):
b. INFECTION — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Brian Clyne, MD

29c. License number: 09200

29d. Date signed *(Month, Day, Year)*: 10/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BRIAN CLYNE UMMS 29 S. GREENE ST BALTIMORE, MD 2201

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997

32. Registrar's Signature: Gina Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31498

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JACK D. JACOBS

2. Date of Death Month Day Year: OCTOBER 17, 1997

3. Time of Death: 12:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: 4218 MORRISON CT.

4b. City, Town, or Location of Death: CURTIS BAY

4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Number: 215-82-7225

6. Sex: 1☒ M 2☐ F

7. Age *(in yrs. last birthday)*: 36 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC. 14, 1960

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE CITY

10c. City, Town or Location: CURTIS BAY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4218 MORRISON CT.

10f. Zip Code: 21226

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CARPENTER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name *(First, Middle, Last)*: LEROY E. JACOBS, JR.

18. Mother's Name *(First, Middle, Maiden Surname)*: FRANCES E. NICOLAUS

19a. Informant's Name/Relationship *(Type, Print)*: LEROY E. JACOBS, JR./ FATHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 516 KUETHE RD., GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: GLEN HAVEN MEM. PK. Date: OCTOBER 20, 1997

20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Lung Cancer — 6 Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?: 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?: 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work?: 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D39505

29d. Date signed *(Month, Day, Year)*: Oct. 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): YUDHISH MARKAN 1406-B CRAIN HWY #202, GLEN BURNIE, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: OCT 20 1997

32. Registrar's Signature: ▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 31499

Item:8,17 per EH G-752 10/20/97 dh
Item:23a part I,II per MD G-752 10/20/97 dh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KHANNA KARMINSKAYA

2. Data of Daath: Month Sept, Day 14, Year 1997

3. Time of Death: 9:15 AM

4a. Facility Nama (If not institution, give street and number): LEVINDALE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-92-9587

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): 12/15/02 SWX, 15M 1902

9. Birthplaca (State or Foreign Country): UKRAINE

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: ☒ 1 Yes 2☐ No

10e. Street and Number: 5715 PARK HEIGHTS AVE.,APT. 312

10f. Zip Code: 21215

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, atc. Specify: WHITE

15. Decedant's Education (Specify only highest grada completad): Elamentary/Secondary (0-12): Collega (1-4or 5+): 2

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): HOMEMAKER

16b. Kind of Businass/Industry: OWN HOME

17. Fathar's Nama (First, Middla, Last): RAFAEL RAFAIL TROTSKY

18. Mother's Nama (First, Middla, Maidan Surnama): FAIGA UNKNOWN

19a. Informant's Name/Ralationship (Type, Print): VICTOR KARMINSKY (SON)

19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 8337 MERRYVIEW DR. BALTIMORE, MD 21244

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)

20b. Piaca of Disposition (Nama of camatary, cramatory or othar placa): ARLINGTON (CHIZUK AMUNO) Data: 9/16/97

20c. Location - City or Town, Stata: BALTIMORE, MD

21. Signature of Funaral Sarvica Licansaa: Joel D Lewis

22. Nama and Addrass of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused tha daath. Do not antar tha moda of dying, such es cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina. (Approximate Intarval Between Onset and Death)

Immediata Cause (Final disaasa or condition rasulting in death): a. Chronic respiratory Failure

Due to (or as a consequance of):

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in daath) Last:

b. CONGESTIVE HEART FAILURE

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

~~Congestive heart failure~~ Atrial Fibrillation

Terminal renal Failure

Diabetes mellitus

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Othar (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Year) | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Dascribe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at the time, date and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, data and placa, and dua to the causa(s) and mannar stated.

29b. Signature and titla of cartifiar: [illegible]

29c. Licansa number: D 10660

29d. Data signed (Month, Day, Year): SEPT. 14, 1997

30. Nama and addrass of parson who completed cause of daath (Item 23e) (Type, Print): R. Webet MD-3901 Greenspring Balto, Md 21211-1345

State Registrar

31. Data filed (Month, Day, Year): OCT 20 1997

32. Registrar's Signatura: Julia Davidson-Randall

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Khanna Karminska 9 / Khanna

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM#23a&28a PER PHYNS. FLM#G752 10/20/97J.

Certificate of Death

Reg. No. 97 31500

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month / Day / Yaar	3. Time of Death
Anna Magdeline Kendrick			September 29, 1997	7 20 PM
4a. Facility Nama (If not institution, give street end number)	4b. City, Town, or Location of Deeth	4c. County of Deeth		
2307 Franklins Chance Court	Fallston	Harford		

Funeral Director

5. Social Security Number	6. Sax 1☐M 2☒F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Yaar: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Data of Birth (Month, Dey, Year)	9. Birthplaca (State or Foreign Country)
214-20-1523		87			Jan 31, 1910	Maryland

Usual Rasidanca of Decedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Fallston	1☐Yas 2☒No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
2307 Franklins Chance Court	21047	USA

11. Marital Stetus	12. Was Decedent Ever in U.S. Armed Forcas?	13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.)	14. Raca - Amarican Indien, Black, Whita, atc.
1☐Navar Married 2☐Married 3☒Widowad 4☐Divorced	1☐Yas 2☒No If Yas, Giva Yeer or Datas:	1☐Yas 2☒No Specify:	Specify: White

15. Dacadent's Education (Specify only highest grede completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elamantary/Sacondary (0-12)	Collaga (1-4or 5+)		
8	n/a	Homemaker	Own Home

17. Fathar's Name (First, Middle, Last)	18. Mothar's Nama (First, Middle, Meiden Surneme)
Kazimir Akelaitis	Eva Simonaitis

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)
Alora K. Roche/Daughter	2307 Franklins Chance Ct., Fallston, MD 21047

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cramation 3☐Ramoval from State 4☐Donation 5☐Othar (Specify)	Holy Redeemer Cemetery	10/2/97	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Bryan W. Clary

22. Nama end Address of Facility: Lemmon Funeral Home, 10 W. Padonia Road, Timonium, MD 21093

Physician /Medical Examiner

23e. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such es cardiac or respiratory errest, shock, or haart failura. List only ona causa on each lina.

		Approximeta Intarval Between Onset and Daath
Immediata Caus? (Fina! disaasa or condition resulting in death)	a. coronary artery disease (myocardial infarction 1988)	1988
Sequantially list conditions, if any, leading to immadiata cause. Enter Undarlying Causa (Diseasa or Injury thet initiated evants rasulting in daath) Last	b. Due to (or as a consequance of):	
	c. Due to (or as a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying causa given in Part I.

hyperthyroidism
diabetes mellitus
ventricular tachycardia, bradycardia

23b. **Did tobacco uae contributa to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes en autopsy performed?	24b. Were autopsy findings availeble prior to completion of causa of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examinar?	26. Placa of Daath (Check only one)	
1☐Yas 2☒No	Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA	Other: 4☐Nursing Homa 5☒Residanca 6☐Othar (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicida 4☐Homicida 5☐Pending Investigation 6☐Could not be datarminad	none	M	1☐Yes 2☐No	

28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒**Cartifying Physician:** To tha best of my knowledga, daath occurred at the time, dete and placa, and dua to tha cause(s) and mannar as stated.
2☐**Medical Examinar:** On tha basis of examinetion end/or investigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signatura end title of certifier	29c. License numbar	29d. Date signad (Month, Dey, Year)
Lawrence Snyder MD	D30122	10/1/97

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print)
Lawrence Snyder, MD 7505 Osler Dr., suite 502, Towson, MD 21204

State Registrar

31. Data filad (Month, Dey, Year)	32. Registrar's Signatura
OCT 17 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requiras thet tha death certificate be executed within 24 hours after daath.
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Baltimore, Maryland 21215-0020

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